

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 982

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

### 1. PLACE OF DEATH:

County Baltimore  
City or town Cummings Mills  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 15 years  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

Mrs. Emma Rosalie Ayler

### 3. (b) Social Security Number

4. Sex Female 5. Color of race White 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Thomas F. Ayler

7. Birth date of deceased (mo., day, yr.) December 1-1873

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 72 Months 3 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Kentucky  
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

12. Name Ferdinand Hise

13. Birthplace Baltimore

14. Maiden name Henrietta Abell

15. Birthplace Pennsylvania

16. Informant William F. Ayler

Address Cummings Mills, Md.

17. Burial, cremation, or removal, Which? Burial Date thereof March 21-1946  
(month) (day) (year)

Cemetery or crematory Lorraine Park

Location Baltimore Co. Maryland

18. Funeral director Burpee Funeral Home

Address 3631 Falls Road

19. 3-20 46 Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Cummings Mills  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Restersburg Road near Gwynnbrook Cr.  
(if rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

### MEDICAL CERTIFICATION

20. DATE OF DEATH 3-18-46 19 46 at 1:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-1-46 to 3-18-46  
and that I last saw him alive on 3/17/46 19 46

Immediate cause of death

myocarditis

Due to

arteriosclerosis

Due to

Influenza

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

James L. Saffell

M. D. or other

Address Restersburg Rd. Date signed 3-18-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

03102

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Charles  
 City or town Rock Point  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Florence Bailey

## 3.(b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed  
 6.(b) Name of husband or wife Jerry Bailey 8.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) November 6, 1882  
 8. AGE: Years 63 Months 4 Days 20 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Rock Point, Maryland  
 (Town, county, and state)  
 10. Usual occupation Housework  
 11. Industry or business House  
 12. Name James Lucas  
 13. Birthplace Bryantown, Maryland  
 14. Maiden name Emily Freeman  
 15. Birthplace ?

16. Informant Hospital records  
 Address Catonsville-28, Md.

17. Buried Date thereof 4-19-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Spring Grove State Hospital  
 Location Catonsville 28, Maryland

18. Funeral director Spring Grove State Hospital  
 Address Catonsville 28, Maryland

19. 4-19-46 Harry J. Miller Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 1946 at 8:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 20 1946 to March 26 1946  
 and that I last saw her alive on March 26 1946

Immediate cause of death Chronic myocarditis DURATION indef.

Due to Hypertensive cardiovascular disease " "

Other conditions Diabetes mellitus " "

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other \_\_\_\_\_

Address Catonsville-28, Md. Date signed 3-27-46

RECEIVED

APR 22 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catoonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 11 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 11 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3317 RUECKERT AVE.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Eugene N. BAKER

## 3. (b) Social Security Number

4. Sex m 5. Color or race w 6.(a) Single, married, widowed, or divorced widowed  
 6.(b) Name of husband or wife Annie E. CHANCE Baker  
 7. Birth date of deceased (mo., day, yr.) Feb. 14 1872 6.(c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 74 Months 1 Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Md  
 (Town, county, and state)

10. Usual occupation Retired Druggist

11. Industry or business

FATHER 12. Name William T. BAKER

13. Birthplace Md (?)

MOTHER 14. Maiden name Sarah NORVILLE

15. Birthplace (?) Md.

16. Informant Hospital records

Address

17. Burial Date thereof 3/21/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. 3-18 19 46 unwed wife  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 19 46 at 11 25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 19 46 to March 17 19 46  
 and that I last saw him alive on March 17 19 46

Immediate cause of death

Pulmonary Edema DURATION 10 hrs

Due to Myocardial insufficiency

Due to

Other conditions bilat. hemia.

Amnesia bilat.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Broken Teeth

23. SIGNATURE

M. D. or other

Address Spring Grove, Catoonsville Date signed 3.17.46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47a

## CERTIFICATE OF DEATH

02340

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Middle River  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Bird River Rd Box 48 Route 14

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Middle River  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Bird River Rd Box 48 Route 14

(If rural, give LOCATION)

No

2.(a) If veteran, name war

## 3. (a) FULL NAME

Ernest F Bartels

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Catherine Bartels Weaver

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Sept 23 1873

8. AGE: Years 72 Months 5 Days 25 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore County Md  
 (Town, county, and state)

10. Usual occupation Foreman11. Industry or business Balto County Roads12. Name Charles Bartels13. Birthplace Germany14. Maiden name Emma Unknown15. Birthplace Md.16. Informant Mrs Ernest F BartelsAddress Bird River Rd Box 48 Route 14

17. Burial Date thereof 3-23-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Moreland ParkLocation Taylor Ave Balto Co18. Funeral director Lascahn Funeral HomeAddress 7401 Belair Road

19. Mar 21 1946 John G. Brimely  
 (Date rec'd by registrar) (Signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mch 20 1946 10.20 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

March 8 1946 to March 20 1946  
 and that I last saw him alive on March 20 1946

Immediate cause of death

Carcinoma of Lung

DURATION

1 yr

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations noAutopsy results no Date of op. \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

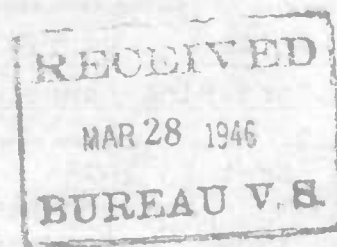
Injured at work? \_\_\_\_\_

23. SIGNATURE James F. White M.D.

M. D. or other

Address 7601 Easton Ave. Balto. 24 Date signed 3/21/46

Dr. White  
7601 Eastern Ave



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 528

## CERTIFICATE OF DEATH

02341  
Reg. Dist. No. 41

## 1. PLACE OF DEATH:

County Baltimore  
City or town Dundalk, Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Clara Beckman

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Paul Beckman

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Aug 26 - 1883

8. AGE: Years 62 Months 6 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore  
(Town, county, and state)

10. Usual occupation \_\_\_\_\_

11. Industry or business at home12. Name Frances Neighoff13. Birthplace Baltimore14. Maiden name Katherine Gilbert15. Birthplace Baltimore16. Informant Mrs. Grace FischerAddress 11 Central Ave17. Burial Date thereof March 21, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Landon ParkLocation City16. Funeral director Wesley Funeral HomeAddress 2008 Orleans St19. 3 - 19 19 46 Arthur H. Hedges  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town Dundalk, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 11 Central Ave  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 19 46 at 10:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Coronary Occlusion DURATION 5 m.Due to A-S-C-V Disease

Due to \_\_\_\_\_

Other conditions C. of Urinary Bladder 7 mos.

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE M B Davis M.D.Address 2008 Orleans St Date signed 3/18/46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

### 1. PLACE OF DEATH

County Baltimore County  
City or town Rockdale  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3/4 hour  
Hospital, institution, or street address where death occurred:  
3634 Marriotts Lane  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Baltimore County Baltimore Co.  
City or town Rockdale  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3634 Marriotts Lane  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Baby Boy Best

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

### 6.(b) Name of husband or wife

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) March 16, 1946

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ of less than one day \_\_\_\_\_ hrs. 45 min.

9. Birthplace 3634 Marriotts Lane  
(Town, county, and state)

### 10. Usual occupation

### 11. Industry or business

12. Name Louis Alton Best

13. Birthplace Baltimore Md

14. Maiden name Madelaine Margaret Jackson

15. Birthplace Baltimore - Md.

16. Informant Mrs. William A. Best

Address 3634 Marriotts Lane

17. Burial (Burial, cremation, or removal? Which?) Date thereof March 18-46  
(month) (day) (year)

Cemetery or crematory London Park

Location Fredrick Rd. Balto. Md.

18. Funeral director Frank H. Newell

Address Pikesville, Maryland

19. 3/17/46 (Date rec'd by registrar) 1946 Frank E. Martin Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 16 1946 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 1946 to March 16 1946

and that I last saw him alive on March 16 1946

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Miscarriage  
(Prematurity at 5 months)

Due to Cause un-determined

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations no operation

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Joshua H. Armistead M.D. M. D. or other \_\_\_\_\_

Address 4419 Windsor Mill Rd. Date signed 3/16/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 26 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 72

## CERTIFICATE OF DEATH

Reg. Dist. No. 02343 37

## 1. PLACE OF DEATH:

County BaltimoreCity or town Corbett  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Corbett  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) Is veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Elizabeth Billingsley

## 3. (b) Social Security Number

## 4. Sex

F.

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Walter

## 7. Birth date of deceased (mo., day, yr.)

May 9, 1849

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

9610-hrs.min.

## 9. Birthplace

Germany  
(Town, county, and state)

## 10. Usual occupation

Homemaker

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Rager

## 13. Birthplace

Germany

## 14. Maiden name

Unknown

## 15. Birthplace

Germany

## 16. Informant

Mrs. W. B. Billingsley

## Address

Corbett, Balto Co., Md.

## 17.

Burial  
(Burial, cremation, or removal. Which?)Date thereof Mar 9, 1946  
(month) (day) (year)

## Cemetery or crematory

West Liberty

## Location

Balto. Co., Md.

## 18. Funeral director

Samuel M. Bivals

## Address

Spauls, Md.

## 19.

March 31, 1946  
(Date rec'd by registrar)Wilmer C. Ensor

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 6 19 46 at 7:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 40, to Mar 6 19 46and that I last saw him alive on Mar 6 19 46

Immediate cause of death

Chronic myocarditis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

G. L. France

M. D. or other

Address Parlton, Md. Date signed 3/21/46

RECEIVED  
MAR 11 1946  
BUREAU OF



PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

02344

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State

(b) County

(c) City or town

(If outside city or town limits, write RURAL and give town)

(d) Street No.

(If rural give location)

(e) Citizen of foreign country?

(Yes or No)

If yes, name country

## 3 (a) FULL NAME

3 (b) If veteran, name war

none

3 (c) Social Security Account

No.

none

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced.

Married

6 (b) Name of husband or wife

H. Monroe Blizzard

6 (c) If alive, give age

years

7. Birth date of deceased (mo., day, yr.)

May 24, 1898

8. AGE:

Years

Months

Days

If less than one day

47

9

9

hr.

min.

9. Birthplace Centerville, Md.

(Town, county, and state)

10. Usual Occupation

Housewife

11. Industry or business

FATHER

12. Name

John Schuyler

13. Birthplace

Centerville, Md.

MOTHER

14. Maiden Name

Josephine Richardson

15. Birthplace

Centerville, Md.

16 (a) Informant

Mr. H. Monroe Blizzard

(b) Address

625 Orpington Rd.

17 (a)

Burial

(b) Date thereof

3/5/46

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory

Druid Ridge Cem.

Location

Pikesville, Md.

18 (a) Funeral director

WM. J. TICKNER &amp; SONS

(b) Address

Balto., Md.

19 (a)

(Date rec'd by registrar)

W. H. Redneck

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

3/3

1946, at 1<sup>40</sup> M

21. I certify that death occurred on the date above stated; that I attended deceased from Sept 1945, to March 3 1946, and that I last saw her alive on March 2 1946.

Immediate cause of death

Carcinoma of Cervix

Duration

275

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

1945 - March

Major findings of operation:

Carcinoma of Cervix

of autopsy:

## PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature

W. H. Redneck

Address

5217 Parkman Rd

Date signed 3/3/46

## INSTRUCTIONS FOR MEDICAL CERTIFICATION

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### WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

### DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

### DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

### DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

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For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

02345

P

## 1. PLACE OF DEATH:

County..... *Balto.*City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred.....  
*Mary Villa*

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... *Md.* County..... *Balto.*City or town.....  
(If outside city or town limits, write RURAL and give nearest town)Street No..... *Bellona Ave.*  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

*Sarah M. S. Boyd*

## 3. (b) Social Security Number

4. Sex.....

*Female*

5. Color or race.....

*White*

6. (a) Single, married, widowed, or divorced

*Divorced*

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....  
*May 9<sup>th</sup> 1894*

8. AGE: Years Months Days If less than one day

*57 10 13* hrs. min.

9. Birthplace.....

*Balto. Md.*  
(Town, county, and state)10. Usual occupation.....  
*at home*

11. Industry or business.....

12. Name.....

*John A. Strick*  
*Balto. Md.*

13. Birthplace.....

*Balto. Md.*

14. Maiden name.....

*Isabelle MacDonald*

15. Birthplace.....

*Balto. Md.*

16. Informant.....

*Edgar Boyd*  
*112 Westwood Pl.*17. (Burial, cremation, or removal. Which?) Date thereof.....  
(month) (day) (year)*Burial* *3/20/46*  
*Holy Redeemed*

18. Location.....

*Balto. Md.*

19. Funeral director.....

*E. J. Ganning & Son*  
*1938 E. Lafayette Ave.*

20. (Date rec'd by registrar).....

*3/23/46* *U. W. H. H. H. H.*  
*L. P.*

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... *Mar. 22* 19 *46* at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*November 9* 19 *46* to *March 22* 19 *46*and that I last saw him..... alive on..... *March 21* 19 *46*

Immediate cause of death.....

*Carcinoma of uterus*DURATION..... *6 mos.*

Due to.....

Due to.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

## CERTIFICATE OF DEATH

02346

Reg. Dist. No. 41

## 1. PLACE OF DEATH:

County BaltimoreCity or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BALTO.City or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1929 Cedar Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

John Bradach BRADACH

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widowed6.(b) Name of husband or wife Frances Ratay

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 27, 1860

8. AGE: Years Months Days If less than one day

85 2 28 ..... hrs. .... min.9. Birthplace Austria

(Town, county, and state)

10. Usual occupation Mine examiner

11. Industry or business

12. Name John Bradach13. Birthplace Austria14. Maiden name Dont know

15. Birthplace

16. Informant Rudolph G. BradachAddress 1929 Cedar Lane17. Cremation Date thereof March 25, 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Loudon ParkLocation Balto Md18. Funeral director Ulrich Funeral HomeAddress 2008 Orleans St19. 3/24/46 H. Mclean

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 19 46, at 10 30 9 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19 43 to March 19 46and that I last saw him alive on March 21 19 46

Immediate cause of death

Chronic Myocarditis

DURATION

3 yrs.Due to Ascar. 5 year

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. B. Davis M.D.Address Dundalk, Md. Date signed 3/23/46

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
APR 3 1946  
BUREAU V.S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02347

Reg. Dist. No. 32

### 1. PLACE OF DEATH:

County Baltimore  
City or town Mount Wilson  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 0 yrs., 0 mos., 10 days  
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium  
How long in hospital or institution? 0 yrs., 0 mos., 10 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Charles Co.  
City or town Potomac Heights, Indian Head  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 21 Delta Place  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3.(a) FULL NAME

Mrs. Madeline Bullock

### 3.(b) Social Security Number

# Unknown

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Linwood Bullock  
6.(c) If alive, give age 23 years  
7. Birth date of deceased (mo., day, yr.) November 1, 1924  
8. AGE: Years 21 Months 4 Days 8 If less than one day hrs. min.

9. Birthplace Charles Co., Maryland  
(Town, county, and state)

10. Usual occupation Housewife

### 11. Industry or business

MOTHER FATHER  
12. Name Lewis Rison  
13. Birthplace Charles Co., Maryland  
14. Maiden name Mae Posey  
15. Birthplace Charles Co., Maryland

16. Informant Mrs. Madeline Bullock  
Address 21 Delta Place, Indian Head, Md.

17. Burial Date thereof Mar. 11, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Nanjemoy Cemetery  
Location Nanjemoy, Maryland

18. Funeral director Hunt & Ryan  
Address Waldorf, Maryland

19. March 9, 1946 Earl T. Webster  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1946 at 12:25 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 27, 1946 to March 9, 1946 and that I last saw her alive on March 9, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 14 Mos.

Due to Tubercle Bacilli

Due to

Other conditions Empyema - Tuberculous and Streptococci Unknown  
(Include pregnancy within 8 months of death)

Major findings of operations No operation Date of op.

Autopsy results No autopsy  
PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Stewart S. Shaffer M.D. M. D. or other  
Address Mount Wilson, Md. Date signed 3/9/46

MARGIN RESERVED FOR BINDING

VS A15 9:45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Rec'd - 3-11-46 Dr. S. S. Shaffer

RECEIVED

MAR 13 1946

BUREAU OF



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

02348

### 1. PLACE OF DEATH:

County Baltimore Co.  
City or town Sweet Air Md  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 87 yr 9 mo

### 3. (a) FULL NAME

Katherine M. Burk

### 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife Andrew Burk

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) June 15, 1858

8. AGE: Years 87 Months 9 Days 0 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Blenheim Balto Co. Md.  
(Town, county, and state)

10. Usual occupation House work at

11. Industry or business Home

12. Name John Trapp

13. Birthplace Germany

14. Maiden name Magdalena Beck

15. Birthplace Germany

16. Informant Mr. William H. Burk

Address Blenheim Md.

17. Burial Date thereof Mar. 18, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Johns Lutheran Church

Location Blenheim Balto Co., Md.

18. Funeral director Elmer W. Conklin & Son

Address 924 E. Eager St Balto - 2 - Md.

19. 3-18 46 unrecorded  
(Date rec'd by registrar) (month) (day) (year) Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County \_\_\_\_\_

City or town Sweet Air Md. Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Baltimore Co. Blenheim Rd.  
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No

### MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 15, 19 46, at 4:30 M

21. I CERTIFY that death occurred on the date above stated. That I attended deceased from October 28 19 37, to March 15 19 46, and that I last saw her alive on March 14, 19 46.

Immediate cause of death Coronary Heart Failure

### DURATION

2 months

Due to General Arteriosclerosis 5 yrs

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

### PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Clifford F. Hudson Md.  
Fork 2nd M. D. or other

Address \_\_\_\_\_ Date signed 3/16/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

On. Hudson  
Fork Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

## CERTIFICATE OF DEATH

02349

Reg. Dist. No. 43

<b>1. PLACE OF DEATH:</b> County <u>Baltimore</u> City or town <u>Fullerton</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <u>Belair Rd and Fitch Ave</u> How long in hospital or institution?				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Baltimore</u> City or town <u>Fullerton</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>Belair Rd and Fitch Ave</u> (If rural, give LOCATION) 2. (a) If veteran, name war			
<b>3. (a) FULL NAME</b> <u>Mamie J Burkhardt</u>				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>Female</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Married</u>			
<b>6. (b) Name of husband or wife</b> <u>William A Burkhardt</u> <b>6. (c) If alive, give age</b> _____ years							
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>May 5 1891</u>							
<b>8. AGE:</b> Years <u>54</u>		Months <u>10</u>		Days <u>10</u>		If less than one day _____ hrs. _____ min.	
<b>9. Birthplace</b> <u>Baltimore County Md</u> (Town, county, and state)							
<b>10. Usual occupation</b> <u>At Home</u>							
<b>11. Industry or business</b>							
FATHER	<b>12. Name</b> <u>Frank Winkler</u>						
	<b>13. Birthplace</b> <u>Baltimore County Md</u>						
MOTHER	<b>14. Maiden name</b> <u>Catherine Klein</u>						
	<b>15. Birthplace</b> <u>Baltimore County Md</u>						
<b>18. Informant</b> <u>Mr. William A Burkhardt</u> <b>Address</b> <u>Belair Rd &amp; Fitch Ave</u>							
<b>17. Burial</b> <u>Burial</u> <b>Date thereof</b> <u>Mch 19 1946</u> (Burial, cremation, or removal. Which?) (month) (day) (year) <b>Cemetery or crematory</b> <u>Parkwood</u> <b>Location</b> <u>Taylor Ave Baltimore Co</u>							
<b>18. Funeral director</b> <u>Lassahn Funeral Home</u> <b>Address</b> <u>7401 Belair Road</u>							
<b>19. (Date rec'd by registrar)</b> <u>Mar 18 1946</u> <b>Registrar</b> <u>Wm. E. Ruffin</u>							

MEDICAL CERTIFICATION	
<b>20. DATE OF DEATH</b> <u>March 15 1946</u> at <u>6:15</u> M	
<b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>Nov 1 1945</u> to <u>March 15 1946</u> and that I last saw him <u>alive</u> on <u>March 15 1946</u>	
<b>Immediate cause of death</b> <u>Respiratory Failure</u>	<b>DURATION</b> <u>30 Hrs.</u>
<b>Due to</b> <u>Congestive Hypertension</u>	<u>18 Days</u>
<b>Due to</b> <u>Chronic Decompensation</u>	<u>3 yrs.</u>
<b>Other conditions</b> <u>Diabetes Mellitus</u> <u>Chronic Habitual Alcoholism</u>	<u>18 yrs.</u> <u>3 wks.</u>
(Include pregnancy within 8 months of death)	
<b>Major findings of operations</b> _____	
_____ Date of op. _____	
<b>Autopsy results</b> _____	
<b>PHYSICIAN:</b> Please underline the cause to which death should be charged statistically.	
<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following:	
<b>Accident, suicide, or homicide</b> _____	<b>Date of</b> _____
<b>Where did injury occur?</b> _____ (City or town) (County) (State)	<b>Injured at home, farm, industry, public place (where?)</b> _____
<b>Means of injury</b> _____	<b>Injured at work?</b> _____
<b>23. SIGNATURE</b> <u>Charles F. O'Donnell M.D.</u> <b>M. D. or other</b>	
<b>Address</b> <u>7301 York Rd</u>	<b>Date signed</b> <u>3/16/46</u>

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Information obtained by  
telephone from W. Cook Inc.  
3/16/46 yhl

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County Balto  
City or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto  
City or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Holder Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Florence M. Carlyle

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

Louis Carlyle

7. Birth date of  
deceased (mo., day, yr.)

Mar 29<sup>th</sup> 1872

8. AGE:

73

Years

Months

Days

If less than one day

11

16

hrs.

min.

9. Birthplace

Balto. Md.

10. Usual occupation

Honor wife

11. Industry or business

At home

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw her alive on

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 15<sup>th</sup> 1946 at 8<sup>30</sup> A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1945 to Mar 15 1946  
and that I last saw her alive on Mar 14 1946

Immediate cause of death Cardio-vascular-hypertensive disease

Due to Cerebral

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Rec'd

V.S.

3/16/46



02351

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(169)

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH

County BaltimoreCity or town Lutherville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Residence institution, or street address where death occurred

Railroad Ave. - Lutherville

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County BaltimoreCity or town Lutherville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 10 Railroad Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war World II

## 3. (a) FULL NAME

Ernest William Carroll, WILLIAM ERNEST

## 3. (b) Social Security Number

1. Sex Male5. Color or race Colored6.(a) Single, married, widowed, or divorced Single

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 1946 at 9:30 approx P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

None 19..... to 19.....and that I last saw him alive on 19.....Immediate cause of death Fractured skull, cervical spine, right & left legs, compound DURATION 3 1/2 hrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operation..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of March 21, 1946Where did injury occur? Lutherville Baltimore Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Private RR trackMeans of injury RR accident Injured at work? No23. SIGNATURE Bollin C. Hudson M.D. D.H.F.

M. D. or other

Address Towson 4, Md Date signed 3/22/46

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Aug. 1, 19248. AGE: Years 24 Months 7 Days 20 If less than one day

hrs. min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation Cook

11. Industry or business

12. Name James A. Carroll13. Birthplace Annapolis, Md.14. Maiden name Etta Swigley15. Birthplace Lutherville, Md.16. Informant Mrs. Etta C. CarrollAddress 10 Railroad Ave.17. Burial (Burial, cremation, or removal. Where?) March 26, 1946

Date thereof (month) (day) (year)

Cemetery or crematory Mount HopeLocation Baltimore Co. (TOWSON) Md.18. Funeral director Mrs. Geo. W. HallmanAddress 1651 Duval Hill Ave.19. March 25 1946 D. W. Hudson

(Date rec'd by registrar) Registrar

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age

is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 472

## CERTIFICATE OF DEATH

03193

Reg. Dist. No. 38

1. PLACE OF DEATH: Baltimore  
 County.....Towson  
 City or town.....W. 3 Res  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
601 W. Joppa Road  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....MD County.....Prince Edward  
 City or town.....Washington Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION) ☒  
 2.(a) If veteran, name war.....40

## 3. (a) FULL NAME

Theodore Carter Jr.

## 3. (b) Social Security Number

4. Sex.....M 5. Color or race.....W. 6.(a) Single, married, widowed, or divorced.....Single  
 6.(b) Name of husband or wife.....  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.).....Oct 8 - 1887

8. AGE: Years.....58 Months.....5 Days.....22 If less than one day..... hrs..... min.....

9. Birthplace.....Appomattox Va  
 Town, county, and state

10. Usual occupation.....Farmer

11. Industry or business.....

12. Name.....Theodore Carter

13. Birthplace.....Va

14. Maiden name.....Mary J. Cobb

15. Birthplace.....Va

16. Informant.....The Dr. J. P. M. Carter

Address.....705 N. Chase St. Richmond

17. Date thereof.....Mar 31 - 1946

(Burial, cremation, or removal) Which?.....Removal

Cemetery or crematorium.....Spring Brook

Location.....Washington Heights Va

18. Funeral director.....Burham & Co

Address.....23247 6th Ave. St.

19. Date rec'd by registrar.....Mar 30 46

Registrar.....Wm. J. Carter

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....Mar 30 - 1946, at 2:45 P.  
 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Mar 1st 1946, to Mar 30 1946  
 and that I last saw him alive on Mar 26 1946

Immediate cause of death.....

DURATION

Carcinoma of Prostate 3 mos.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE.....Danice of el. Tho. Jensen

M. D. or other

Address.....Towson 4. Md Date signed.....3/30/46

RECEIVED  
MAY 3 1946  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

## CERTIFICATE OF DEATH

Reg. Dist. No. 02352 41

### 1. PLACE OF DEATH:

County Baltimore  
City or town Sumner Sta.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 year  
Hospital, institution, or street address where death occurred:  
131 Willow Court  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Baltimore  
City or town Sumner Sta. Dundalk 2.2 mi  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 131 Willow Court  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Winnie Carter

### 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female col W.

### 6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1901

8. AGE: Years Months Days It less than one day  
44 4 28 hrs. min.

9. Birthplace South Carolina  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Andrew Gilmore

13. Birthplace S. C.

14. Maiden name Hanna Campbell

15. Birthplace S. C.

16. Informant Willie Hickenbottom

Address 131 Willow Court

17. Burial Date thereof Apr. 2, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetary or crematory

Location Chester, S. C.

18. Funeral director Eloy D. Wilson

Address 1000 Brantley Ave

19. 4/4/46 19 1946  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 31st 1946 at 3:55 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 30th 1946 to March 31st 1946  
and that I last saw her alive on March 31st 1946

Immediate cause of death Cerebral apoplexy

Due to arteriosclerosis

Due to hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Thomas, M.D.

Address 107 N. Main St. Sumner Sta. Date signed 3/31/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

APR 3 1946

BUREAU V.B.

RECEIVED FOR CHAIRMAN OF BOARD

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

## CERTIFICATE OF DEATH

02353

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Balt. Co.City or town Bossex, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 years.

Hospital, institution, or street address where death occurred:

223 S. Maryn Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balt.City or town Bossex

(If outside city or town limits, write RURAL and give nearest town)

Street No. 223 Maryn Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war none

## 3. (a) FULL NAME

Joseph Ceika

## 3. (b) Social Security Number

none4. Sex M 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Barbara Marie Ceika6. (c) If alive, give age deceased years7. Birth date of deceased (mo., day, yr.) Sept 13 - 18658. AGE: Years 80 Months 6 Days 16 If less than one day9. Birthplace Progne, B. Lewis

(Town, county, and state)

10. Usual occupation Harness Maker

11. Industry or business

12. Name unknown

13. Birthplace

14. Maiden name unknown

15. Birthplace

16. Informant Cma Marie CeikaAddress 223 S. Maryn Ave. Bossex17. Burial Date thereof 3/1/46

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Mount Pleasant Ph.Location Barthville - Balt. Co.18. Funeral director Wm. O. B. Co.Address 1217 St. Paul St. Balt. 2.19. 3-29 19 46 W. Nedpelt

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH March 29 19 46 at 2 P.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19 40 to March 29 19 46and that I last saw him alive on March 29 19 46

Immediate cause of death

Chronic Pharyngitis

## DURATION

2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations see

Date of op.

Autopsy results see

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE James F. White M.D.Address 7604 Eastern AveDate signed 3/29/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BMD*

## CERTIFICATE OF DEATH

02354

Reg. Dist. No. *38*

1. PLACE OF DEATH: *Baltimore*  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
*616 Charles Street Avenue*  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....*Penna.* County.....*Clinton*  
 City or town.....*Mill Hall*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... ☒

3. (a) FULL NAME *Sarah Elizabeth Cheesman* 3. (b) Social Security Number

4. Sex *Female* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Widow*  
 6. (b) Name of husband *Asbury E. Cheesman*  
 7. Birth date of deceased (mo., day, yr.) *February 11, 1868* 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years *78* Months *—* Days *25* If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace *Mill Hall, Penna.*  
 (Town, county, and state)  
 10. Usual occupation *Housewife*  
 11. Industry or business *At Home*  
 FATHER 12. Name *Abram Kriedler*  
 13. Birthplace *Penna.*  
 MOTHER 14. Maiden name *Johanna ~~Stee~~ Myers*  
 15. Birthplace *Penna.*

16. Informant *Calvin A. Cheesman*  
 Address *616 Charles St. Ave. Towson 4, Md.*  
 17. *Removal* Date thereof *March 10, 1946*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory *A. L. McCloskey Funeral Home*  
 Location *Mill Hall, Penna.*  
 18. Funeral director *John Burns' Sons*  
 Address *Towson, Maryland*  
 19. *3/9* *46* *G. M. Bacon*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *March 8* 19*46* at *12:40 P.*  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Feb. 24* 19*45* to *Mar. 8* 19*46*  
 and that I last saw him alive on *March 8* 19*46*

Immediate cause of death.....  
*Chronic myocarditis*  
*chronic nephritis with*  
*hypertension*  
 Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

DURATION  
*1 yr. +*  
*1 yr. +*

Major findings of operations.....  
 Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?.....  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE *G. M. Bacon, M.D.* M. D. or other  
 Address *2810 Taylor Ave.* Date signed *3/9/46*



RECEIVED  
MAR 11 1946  
BUREAU V.S.

CONGRESS  
JANSEN LEDGER

WILEY PAPER CO



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

## CERTIFICATE OF DEATH

Reg. Diat. No. 02355 57

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Cockeysville (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Lifetime  
 Hospital, institution, or street address where death occurred:  
13 Years  
 How long in hospital or institution? -

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Cockeysville (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Western Run Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

Edward Franklin Cole

## 3. (b) Social Security Number

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

May (nee Ryan)

## 7. Birth date of

deceased (mo., day, yr.)

April 30, 1874

B. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

7110-

..... hrs.

..... min.

## 9. Birthplace

Balto. Co. Md.  
(Town, county, and state)

## 10. Usual occupation

General Laborer

## 11. Industry or business

Shadrach K. Cole

MOTHER FATHER

## 12. Name

Shadrach K. Cole

## 13. Birthplace

Balto. Co. Md.

## 14. Maiden name

Rebecca J. Harris

## 15. Birthplace

Balto. Co. Md.

## 16. Informant

Mr. Leroy Brown

## Address

Cockeysville Md.

## 17.

(Burial, cremation, or removal. Which?)

Date thereof

May 5, 1946  
(month) (day) (year)

## Cemetery or crematory

Black Rock

## Location

Butler, Balto. Co. Md.

## 18. Funeral director

London M. Brooks

## Address

Sparks, Md.

## 19.

3-4  
(Date rec'd by registrar)-46Wilmer C. Emsor

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Mar 2, 1946 at 4 P. M

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7-241943, to 3-21946

## and that I last saw him alive on

Feb 281946

## Immediate cause of death

Hemiplegia

## DURATION

11 mo.

## Due to

Cerebral Hemorrhage11 mo.

## Due to

Hypertensive E.V.D. 3 yrs3 yrs

## Other conditions

arteriosclerosis3 yrs

(Include pregnancy within 3 months of death)

## Major findings of operations

None

Date of op. ....

## Autopsy results

## PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

## Accident, suicide, or homicide

Date of .....

## Where did injury occur?

(City or town)

County

(State)

## Injured at home, farm, industry, public place (where?)

## Means of injury

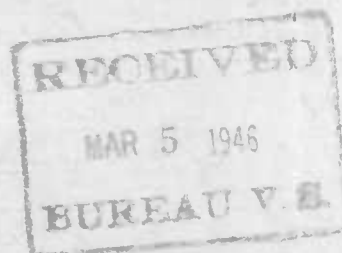
## Injured at work?

## 23. SIGNATURE

D.D. Caples, M.D.

M. D. or other

Address Reisterstown Md.Date signed 3-2-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

02356

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 years, 4 months, 4 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 8 years, 4 months, 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 150 S. Morley St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Catherine E. Correr (Corrieri)

## 3.(b) Social Security Number

4. Sex f 5. Color or race w 6.(a) Single, married, widowed, or divorced widowed6.(b) Name of husband or wife Charles Corrieri6.(c) If alive, give age no years7. Birth date of deceased (mo., day, yr.) June 2, 18838. AGE: Years 62 Months 9 Days 6 It less than one day  
.....hrs. ....min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation housewife11. Industry or business home12. Name William J. Suit13. Birthplace Maryland14. Maiden name Martha Roach15. Birthplace Virginia16. Informant Hospital RecordsAddress Catonsville 28, Md.17. Burial Date thereof 3-11-46  
(Burial, cremation, or removal) (month) (day) (year)Cemetery or crematory London ParkLocation Baltimore, Md.18. Funeral director George A. TaylorAddress Catonsville, Md.19. 3-11 46 Isadore Tuerk  
(Date rec'd by registrar) (year) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 19 46 at 7:55 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
November 4 19 37 to March 8 19 46and that I last saw h. er alive on March 8 19 46Immediate cause of death  
Terminal Bronchopneumonia, right DURATION 5 days  
lower lobe.Due to Myocardial insufficiency Indef.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results NO

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isadore Tuerk M. D. or otherCatonsville 28, Md.Address Date signed 3/9/46

RECEIVED

MAR 12 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 712

## CERTIFICATE OF DEATH

02357

P

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Helix Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 + years  
 Hospital, institution, or street address where death occurred:  
5622 Canille Ave  
 How long in hospital or institution? ✓

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Bales  
 City or town Helix Park  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5622 Canille Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Frank W. Day

## 3. (b) Social Security Number

213-01-1902

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Widowed

6. (b) Name of husband or wife Helen Day

6. (c) If alive, give age. Dead years7. Birth date of deceased (mo., day, yr.) Mch. 25 - 18838. AGE: Years Months Days If less than one day  
62 11 13 hrs. min.9. Birthplace Baltimore - Md Hamford VA.  
(Town, county, and state)10. Usual occupation Seaman11. Industry or business no business12. Name Father 2 Day13. Birthplace N. Y. C. N. Y.14. Maiden name Peeres15. Birthplace Baltimore Md16. Informant Mrs Phillip Reinhardt (Wife)Address 5622 Canille Ave Helix Park17. Burial Date thereof Mar 16-46  
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory London Park Cem -Location Balto Md. Federal Ave.18. Funeral director John R. KanyAddress 1242 Lind Ter. Arden - Md19. 3/15-46 A. W. Hedrick  
(Date rec'd by registrar) (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 19 46, at A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 43, to March 13 19 46and that I last saw him alive on March 13 19 46Immediate cause of death Angina PectorisDue to Queens & coronary vessels

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. HedrickAddress 1014 Francis Ave. B37 Date signed 3/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02358

★ Reg. Dist. No. 31

## 1. PLACE OF DEATH:

County BaltimoreCity or town Granite  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Granite  
(If outside city or town limits, write RURAL and give nearest town)Street No. Waverly Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Joseph Dennis

## 3. (b) Social Security Number

4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced widowed8. (b) Name of husband or wife Mary B. Dennis7. Birth date of deceased (mo., day, yr.) Nov. 13, 1940 8. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 75 Months 4 Days 0 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Germany  
(Town, county, and state)10. Usual occupation Retired Baker

11. Industry or business

12. Name unknown13. Birthplace "14. Maiden name "15. Birthplace "16. Informant Edward J. DennisAddress Granite Md.17. Burial Date thereof 3-16-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. AlphonsusLocation Woodstock Md.18. Funeral director J.C. WyndhamAddress Edwards City Md.19. 3/13/46 Tom P. Martin  
(Date rec'd by registrar) (19 46) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3-13- 19 46 at 1 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1944 to Mar. 13, 19 46  
and that I last saw him alive on Mar. 12, 19 46

Immediate cause of death

DURATION

Carcinoma of stomach

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Tom P. Martin M. D. or otherAddress Randallstown Date signed 3/13/46



RECEIVED  
MAR 26 1946  
BUREAU V.S.

Evidence for change of age of deceased is shown on MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore 73d

02859

FILM No. 101 MAR 29 1946

# CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:  
County Baltimore  
City or town Pikesville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 60 yrs  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Md County Balto  
City or town Pikesville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Roseland Old Court Rd  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME MARY Josephine Myer Dermies  
3. (b) Social Security Number

4. Sex Female  
5. Color or race white  
6. (a) Single, married, widowed, or divorced widowed  
6. (b) Name of husband or wife Henry A. Dermies  
7. Birth date of March 25th 1883  
deceased (mo., day, yr.)  
6. (c) If alive, give age L years  
8. AGE: Years 83 Months 82 Days 29  
If less than one day  
hrs. min.

9. Birthplace 209 Franklin St - Balto - Md  
(Town, county, and state)  
10. Usual occupation housewife  
11. Industry or business

12. Name Thomas J. Myer  
13. Birthplace BALTO - Md  
14. Maiden name Elizabeth Shriver  
15. Birthplace Union Mills, Md

16. Informant Josephine E. O'Fall  
Address Quincy Mills, Md  
17. BURIAL Date thereof Mar. 23 46  
(Burial, cremation, or removal, which?) (month) (day) (year)  
Cemetery or crematory New Cathedral  
Location Balto Md

18. Funeral director Henry M. Jenkins Sons  
Address McClure Orchard St.  
19. 3-23- 1946  
(Date rec'd by registrar) E E Nichols  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 21 46 1946 at 4 P.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 21 44 1944 to Mar 21 46 1946  
and that I last saw him alive on March 21 46 1946

Immediate cause of death  
Chronic myocarditis  
Arterio Sclerosis  
Arterial Hypertension  
Other conditions Senility  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide. Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE E E Nichols M. D. or other  
Address Pikesville & my Date signed Mar 23-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness of the information is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 25 1946  
BUREAU V.A.

Mr. Nichols  
Capeville

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 304

03104

## CERTIFICATE OF DEATH

Reg. Diat. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months, 22 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 5 months, 22 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. Unknown

(If rural, give LOCATION)

2. (a) If veteran, name war? ?

## 3. (a) FULL NAME

Harvey Doss

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

B. (a) Single, married, widowed, or divorced

Separated

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 28, 1900

8. AGE: Years Months Days If less than one day

4613

hrs. min.

9. Birthplace Roanoke, Virginia

(Town, county, and state)

10. Usual occupation Unknown11. Industry or business Unknown12. Name William Doss13. Birthplace Virginia14. Maiden name Mervinia Beckner15. Birthplace Virginia16. Informant Hospital RecordsAddress Catonsville 28, Maryland17. Burial Date thereof April 19, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Spring Grove State HospitalLocation Catonsville 28, Maryland18. Funeral director Spring Grove State HospitalAddress Catonsville 28, Maryland19. 4-19 1946 Harry D. Miller Registrar

(Date rec'd by Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 19 46 at 4:35 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 19 19 45 to March 13 19 46and that I last saw him alive on March 13 19 46

Immediate cause of death

DURATION

General paresisindef.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isadore Tuerk M. D. or otherIsadore Tuerk, M.D. Catonsville 28, Md. Date signed 3-13-46

RECEIVED

APR 22 1946

BUREAU V.S.

SAC CONTENT

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

Reg. Dist. No. 223642

## 1. PLACE OF DEATH:

County BaltimoreCity or town Relay  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2511 McHenry St  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married8. (b) Name of husband or wife Anne L

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 52 Months 11 Days 19 If less than one day hrs. min.9. Birthplace Baltimore  
(Town, county, and state)10. Usual occupation Steel worker11. Industry or business structural12. Name Isaac Devozen13. Birthplace unknown14. Maiden name Ethel Fisher15. Birthplace unknown16. Informant Anne L DevozenAddress 2511 McHenry St17. (Burial, cremation, or removal. Which?) Burial Date thereof March 23, 1946  
(month) (day) (year)Cemetery or crematory Frieden ParkLocation Baltimore18. Funeral director Harry H. MetzkeAddress 4101 Edmondson Ave19. March 20, 1946 Ger M Kieffer  
(Date rec'd by registrar) (Registrar)

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 19, 1946 at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to coronary occlusionDue to sudden deathOther conditions lung

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Ger M Kieffer

M. D. or other

Address 1010 Leaden Ave Date signed 3-20-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
MAR 23 1946  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

## CERTIFICATE OF DEATH

02361

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 14 years, 8 months, 22 days  
 Hospital, institution, or street address where death occurred:  
 Spring Grove State Hospital  
 How long in hospital or institution? 14 years, 8 months, 22 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Woodlawn  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. unknown  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war -

## 3. (a) FULL NAME

Walter J. Drexel

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced ~~Married~~ Single  
 6.(b) Name of husband or wife Mary Spencer  
 6.(c) If alive, give age unk. years  
 7. Birth date of deceased (mo., day, yr.) March 1, 1880  
 8. AGE: Years 66 Months 0 Days 10 If less than one day hrs. min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation unknown  
 11. Industry or business unknown  
 12. Name Henry C. Drexel  
 13. Birthplace Baltimore, Md.  
 14. Maiden name Mary Vance  
 15. Birthplace Baltimore, Md.

16. Informant Hospital Records  
 Address Catonsville 28, Md.  
 17. Burial Date thereof 3.14.46  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Woodlawn  
 Location Woodlawn, Md.  
 16. Funeral director H. Howard Strong  
 Address 307 W. North Ave.  
 19. 3.14.46 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

2D. DATE OF DEATH March 11 1946 4:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

DURATION

Acute Cardiac Failure  
 Due to  
 Coronary vascular disease  
 Due to  
 Sudden death  
 Inquest  
 Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Geo. L. McKeeffer

M. D. or other

Address 1010 Leekman Date signed 3.12.46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-0

CERTIFICATE OF DEATH *be*Reg. Dist. No. *02368* *30*

## 1. PLACE OF DEATH:

County *Baltimore*City or town *Cotonsville*  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *2 weeks*

Hospital, institution, or street address where death occurred:

*Opety Home*

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Baltimore*City or town *Baltimore*  
(If outside city or town limits, write RURAL and give nearest town)Street No. *1404 Light St.*

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

*William A. Durdig*

## 3. (b) Social Security Number

4. Sex

*Male*

5. Color or race

*White*

6.(a) Single, married, widowed, or divorced

*Single*

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

*March 22 - 1959*

8. AGE: Years Months Days It less than one day

*86**11**10**hrs. min.*

9. Birthplace

*Baltimore Md*  
(Town, county, and state)

10. Usual occupation

*Retired*

11. Industry or business

12. Name

*John T. Durdig*

13. Birthplace

*Md*

14. Maiden name

*Catherine Busch*

15. Birthplace

*Baltimore Md.*

16. Informant

*John E. Cullen*

Address

*4606 Cedar Garden Rd.*

17. Burial (Burial, cremation, or removal, Which?)

*Burial*

Date thereof

*3-6-1946*  
(month) (day) (year)

Cemetery or crematory

*Cathedral*

Location

*Baltimore Md.*

18. Funeral director

*Flannery & Flannery*

Address

*1426 Light St.*19. *3-6* *85* *John T. Durdig*  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Mar 4* 19 *46* at *11:50 P*

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

*Feb 16* 19 *46* to *Mar 4* 19 *46*and that I last saw h..... alive on *Mar 4* 19 *46*

Immediate cause of death

*Chronic Myocarditis*

## DURATION

*2 mon*Due to *Arterio Sclerotic Cardio-**Vascular Disease*

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *John T. Durdig*Address *Cotonsville Md* M. D. or otherDate signed *3-5*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

0236340

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County BaltoCity or town Whitemarsh  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? life

Hospital, institution, or street address where death occurred:

Phila Rd.

How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltoCity or town Whitemarsh  
(If outside city or town limits, write RURAL and give nearest town)Street No. Phila Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Annie M. Edwards

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Arthur R. Edwards

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 26<sup>th</sup> 18748. AGE: Years Months Days It less than one day  
71 7 11 ..... hrs. .... min.9. Birthplace Anne Arundel Co Md  
(Town, county, and state)10. Usual occupation At Home

## 11. Industry or business

12. Name James E. DeBrular13. Birthplace A.A. Co. Md14. Maiden name Virginia Phelps15. Birthplace A.A. Co. Md16. Informant Arthur R. EdwardsAddress Phila Rd17. Burial Date thereof 3/12/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Ebenezer Meth. Cem.Location Balto Co Md18. Funeral director Lassalam Funeral HomeAddress 7491 Belair Rd.3/11/46 19. J. H. Humphreys  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 9<sup>th</sup> 1946 at 10<sup>15</sup> P. M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 8 1945 to March 9 1946  
and that I last saw him alive on March 9 1946Immediate cause of death Coronary Occlusion DURATION 20 min.Due to Arteriosclerotic  
Heart Disease 2 yrs.

Due to .....

Other conditions Multiple  
Hypertrophic Arteritis 3 yrs  
(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. .... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

Clifford F. Hudson, Md23. SIGNATURE J. H. Humphreys M. D. or otherAddress J. H. Humphreys Date signed 3/10/46

RECEIVED  
MAR 22 1946  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 95-6

CERTIFICATE OF DEATH *bc*

Reg. Dist. No. 02364 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 years, 10 mos., 12 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 6 years, 10 mos., 12 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1431 N. Luzerne Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Helen Everts

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced divorced  
 6. (b) Name of husband or wife David Everts  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) May 17, 1897  
 8. AGE: Years Months Days If less than one day  
48 9 24 \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation None  
 11. Industry or business None  
 12. Name John Lumsden  
 13. Birthplace Baltimore Md.  
 14. Maiden name Barbara Kirchbaum  
 15. Birthplace Baltimore Md.

16. Informant Hospital records  
 Address Catonsville-28, Maryland

17. Burial Date thereof 3/15/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Baltimore Md.  
 Location Baltimore Md.

18. Funeral director John C. Miller Inc.  
 Address 2435 E. Oliver St.

19. 3/14 19 46 D. W. Hedrick  
 (Date read by registrar) Registrar DM

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 19 46 at 1:25 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
April 29 19 39 to March 13 19 46  
 and that I last saw him alive on March 13 19 46

Immediate cause of death \_\_\_\_\_ DURATION  
Cardiac fibrillation 12 hrs.  
 Due to Chronic rheumatic heart disease  
with cardiac block 3 days

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Isadore Tuerk, M.D. M. D. or otherAddress Catonsville-28, Md. Date signed 3-13-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02365

## CERTIFICATE OF DEATH

Reg. Dist. No. *44*

## 1. PLACE OF DEATH:

County *Baltimore* - *19*City or town *Sparrows Point*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

*6808 North Point Rd.*

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Do in #1* CountyCity or town *(If outside city or town limits, write RURAL and give nearest town)*Street No. *(If rural, give LOCATION)*

2. (a) If veteran, name war

## 3. (a) FULL NAME

*Omena McKinley Forbes*

## 3. (b) Social Security Number

4. Sex

*Female white married*

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife *Thomas S. Forbes*

7. Birth date of

deceased (mo., day, yr.)

September 14<sup>th</sup> 19016. (c) If alive, give age *50* years

8. AGE:

Years

Months

Days

If less than one day

*44*

.....hrs. ....min.

9. Birthplace

*Virginia*

(Town, county, and state)

10. Usual occupation

*None*

11. Industry or business

*None*

12. Name

*James L. Ford*

13. Birthplace

*Virginia*

14. Maiden name

*Anna V. Zimba*

15. Birthplace

*Virginia*

16. Informant

*Mr. Thomas S. Forbes*

Address

*6806 Old North Point Rd*

17.

*Burial*

Date thereof

*3/22/46*

(Burial, cremation, or removal. Which?)

Cemetery or crematory

*Oakland Cem.*

Location

*Eastern Ave*

18. Funeral director

*John F. Kennedy Inc*

Address

*715 Light St.*

19.

*3/22**XL**A.W. Hedrick**3.M. Registrar*

(Data read by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH *March 19. 46* at *8:27 P.* M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19 *35* mar. 19. 46.and that I last saw him *or* alive on *mar. 19. 46.*

Immediate cause of death

*Pulmonary edema*

DURATION

*15 min.*

Due to

*Cardiac dilatation**15 min.*

Due to

*Hypertensive Cardis**8 yrs.*

Other conditions

*Vascular disease*

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

*Louis N. Pollen M.D.*

M. D. or other

Address *Sparrows Point - Md.* Date signed *3/19/46*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02366

Reg. Dist. No.

238

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Towson, 4, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Since March 6, 1946  
 Hospital, institution, or street address where death occurred:  
Eudowood Sanatorium, Towson, 4, Md.  
 How long in hospital or institution? Since March 6, 1946

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)  
 State Maryland County Frederick  
 City or town Frederick  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. R 7 B # 2  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war ✓

## 3. (a) FULL NAME

Beverly Charles Fouche

## 3. (b) Social Security Number

4. Sex Female 5. Color of race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) December 17, 1940 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Philadelphia Pa  
 (Town, county, and state)

10. Usual occupation none

11. Industry or business

12. Name Curtis B. Fouche13. Birthplace Lagerstown, Md14. Maiden name Margaret Harmon15. Birthplace Frederick Md16. Informant Family Records and HistoryAddress Eudowood Sanatorium, Towson, 4, Md.17. Burial Date thereof 3-18-1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt Olivet CemeteryLocation Frederick, Md.18. Funeral director M. R. Etchison & SonAddress Frederick, Md.19. 3/16 46 W. C. Bridges

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1946 at 5:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 6 1946 to Mar 15 1946  
 and that I last saw him alive on March 15 1946

Immediate cause of death

Pulmonary tuberculosis DURATION about 7 months  
 Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Tuberculosis adnitis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. \_\_\_\_\_

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. C. Bridges M. D. or other \_\_\_\_\_Address Towson, 4, Maryland Date signed 3-15-46

RECEIVED  
APR 2 1946  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

02367

★ Reg. Diat. No. 37

## 1. PLACE OF DEATH:

County BaltimoreCity or town Texas  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 yr 3 mo. 14 daHospital, institution, or street address where death occurred:  
Baltimore County HomeHow long in hospital or institution? 8 yr. 3 mo. 14 da.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Essex  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Catherine Frazier

## 3. (b) Social Security Number

-

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white widow6. (b) Name of husband or wife Joseph Frazier7. Birth date of deceased (mo., day, yr.) Apr. 27, 1863 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 82 Months 11 Days 2 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Germany  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name Henry Bloom13. Birthplace Germany14. Maiden name Christina - unknown15. Birthplace Germany16. Informant Mrs. Viola ShultzAddress Hyndale 24 Md.17. Burial Date thereof Apr. 1, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Stanislas Cem.Location Hyndale Ave.18. Funeral director John. Y. ConnellyAddress 418 Eastern Ave. Essex19. 3/29 1946 W. J. Chilcoat  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3/29 1946 at 9:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 16 1937 to 3/29 1946and that I last saw her alive on 3/25 1946Immediate cause of death Myocardial infarction -Due to arterio sclerosis -Due to Senility -

Other conditions \_\_\_\_\_

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William C. Evans M.D.Address Cockeysville Md. Date signed 3/29/46

M. D. or other

RECEIVED

APR 2 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (E37)

03105

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

## 1. PLACE OF DEATH:

County BaltimoreCity or town Hotel Cliff near Towson  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Hotel Cliff near Towson  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name War \_\_\_\_\_

## 3. (a) FULL NAME

Sister Mary Nicolina Frings

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

8. (b) Name of husband or wife \_\_\_\_\_

8. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 18748. AGE: Years Months Days It less than one day  
72 1 2 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Germany  
(Town, county, and state)10. Usual occupation Housework

11. Industry or business \_\_\_\_\_

12. Name Henry Frings13. Birthplace Germany14. Maiden name Agnes Rath15. Birthplace Germany18. Informant Sr. Mary ClaraAddress Hotel Cliff Md.17. (Burial, cremation, or removal, Which?) Burial Date thereof April 29, 1946  
(month) (day) (year)Cemetery or crematory Notch CliffLocation Glen Auld18. Funeral director Geo. McQuinn, SonAddress 811 N. W. York19. (Date rec'd by registrar) 3/31/46 19. Wm. Hammett Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 19 46 at 10.30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 12 19 45 to Mar. 29 19 46and that I last saw her alive on March 27, 1946 19 46Immediate cause of death A. A. Pharynx

DURATION

5 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Hypertension, Arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John J. Moore Jr. M. D. or otherAddress Towson Date signed Mar 29/46



RECEIVED

APR 15 1946

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 746

## CERTIFICATE OF DEATH

Reg. Dist. No. 02368 33

1. PLACE OF DEATH: Baltimore  
 County.....  
 City or town..... Reisterstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 2 years  
 Hospital, institution, or street address where death occurred:  
 Church Road  
 How long in hospital or institution?..... -

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland County..... Baltimore  
 City or town..... Reisterstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Church Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... No

3. (a) FULL NAME  
 Lydia Magdalena Fritch

3. (b) Social Security Number  
 None

4. Sex..... F 5. Color or race..... W 6. (a) Single, married, widowed, or divorced..... M

6. (b) Name of husband or wife..... Edward Fritch

7. Birth date of deceased (mo., day, yr.)..... July 18 1885 8. (c) If alive, give age..... 51 years

8. AGE: Years..... 60 Months..... 7 Days..... 15 It less than one day..... hrs. .... min.

9. Birthplace..... Halethorpe Balto Co Md  
 (Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... -

12. Name..... Christian Kaline

13. Birthplace..... Halethorpe Md

14. Maiden name..... - Rehbaum

15. Birthplace..... Halethorpe Md

16. Informant..... Edward Fritch

Address..... Church Rd Reisterstown

17. Burial..... Date thereof..... March 7 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Loudon Park Cemetery

Location..... Baltimore Md

18. Funeral director..... Wm Berryman & Sons

Address..... Reisterstown Md

19. 3-6-46..... Dary B. E. Line  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Mar 5 1946 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 5 1946 to Mar 5 1946

and that I last saw her dead Mar 5 1946

Immediate cause of death.....

Congestive Pectoris

DURATION..... 3 mo.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... None Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... None Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... D. D. Caples, M.D.

Address..... Reisterstown Md Date signed..... 3-6-46

CERTIFICATE OF DEATH

RECEIVED

MAR 8 1946

BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 957

## CERTIFICATE OF DEATH

02369

P

Reg. Dist. No. 11

### 1. PLACE OF DEATH:

County Baltimore  
City or town Upper Falls (Rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 38 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Upper Falls (Rural)  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. W. S. Raphael - 1st house S. of Sunshin Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Theodore Franklin Frizzell

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widower  
6.(b) Name of husband or wife Emma 7. Frizzell  
7. Birth date of deceased (mo., day, yr.) June 21, 1857  
8. AGE: Years 88 Months 8 Days 15 It less than one day  
.....hrs. ....min.

9. Birthplace Carrall County, Md.  
(Town, county, and state)  
10. Usual occupation Retired carpenter  
11. Industry or business

12. Name Joel Frizzell  
13. Birthplace Carrall County, Md.  
14. Maiden name Sarah Fraake  
15. Birthplace Carrall County, Md.

16. Informant Alma Barnes  
Address 2225 E. Preston St.  
17. Burial Date thereof March 9, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Western Cemetery  
Location Baltimore, Md.  
18. Funeral director Edward D. Worthington  
Address 21 W. 25th St.

19. March 7, 1946 Registrar and Theodore  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 19 46 at 10:30 PM  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-25 19 39 to 3-5 19 46  
and that I last saw him alive on 3-5 19 46

Immediate cause of death chronic occlusion  
DURATION 4 days

Due to arteriosclerotic heart disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ned Ottodone MD  
M. D. or other

Address Edgewood Md Date signed 3-5-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Batte Co

Miss Caskey  
Gowson

June 11 27

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02371

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

## 1. PLACE OF DEATH:

County BaltimoreCity or town Texas  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 37 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Texas  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Josephine Gagliano

## 3. (b) Social Security Number

## 4. Sex

F

## 5. Color or race

W.

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Joseph

7. Birth date of deceased (mo., day, yr.)

June 1, 1891

6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

54

Months

9

Days

If less than one day

hrs.

min.

## 9. Birthplace

Louisiana, U.S.A.  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

FATHER

## 12. Name

Frank Viola

## 13. Birthplace

Italy

MOTHER

## 14. Maiden name

Frances Bonsino

## 15. Birthplace

Italy

## 16. Informant

Mrs. Richard Gagliano

## Address

Texas, Md.

## 17.

(Burial, cremation, or removal. Which?)

Burial

Date thereof

Mar. 26, 1946  
(month) (day) (year)

## Cemetery or crematory

St. Joseph's

## Location

Texas, Md.

## 18. Funeral director

Samuel M. Brooke

## Address

Sparks, Md.

## 19.

(Date rec'd by registrar)

3-23

19

46Wilmer C. Ensor

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3/23/46 19 45 at 8:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12-1-45 19 45 to 3-23-46 19 46and that I last saw her alive on 3/20/46 19 46

## Immediate cause of death

Coronary arteriosclerosis

## DURATION

1 yr.

## Due to

hypertension

## Due to

myocardial infarction

## Other conditions

None

(Include pregnancy within 3 months of death)

## Major findings of operations

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

## Means of injury

## Injured at work?

## 23. SIGNATURE

James G. Saffell

M. D. or other

Address Rockville, Md. Date signed 3/23/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1946  
57  
9

RECEIVED

MAR 27 1946

BUREAU



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 5 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 839 Hollins St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Albina Galinas

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Married6.(b) Name of husband or wife Charles Galinas6.(c) If alive, give age 56 years7. Birth date of deceased (mo., day, yr.) Jan. 27, 18938. AGE: Years Months Days It less than one day  
53 1 4 .....hrs. ....min.9. Birthplace Lithuania  
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Home12. Name Unknown13. Birthplace Lithuania14. Maiden name Unknown15. Birthplace Lithuania16. Informant Hospital RecordsAddress Catonsville 28, Maryland17. Burial Date thereof 3-5-46  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Holy Redeemer Chm.Location Below Rd18. Funeral director Joseph Kasinski Dr.Address 602 Washington Blvd19. 3/4 46 R.W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 3, 1946 at 5:40 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 6, 1946 to March 3, 1946 and that I last saw her alive on March 3, 1946Immediate cause of death Terminal bronchopneumonia DURATION 18 hoursDue to Chronic alcoholism Indefinite

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Henry C. Mead M.D.HENRY C. MEAD, M.D. or other  
Address Catonsville, Md. Date signed 3/3/46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Carney  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 W. Summit Ave  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Matto Co  
 City or town \_\_\_\_\_  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Summit Ave  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Charles E. Sambrill (Sambrell)

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Nellie E. Sambrill  
 7. Birth date of deceased (mo., day, yr.) July 20-1869  
 8. AGE: Years 76 Months 7 Days 23 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore  
(Town, county, and state)10. Usual occupation retired

11. Industry or business \_\_\_\_\_

FATHER 12. Name James H. Sambrill  
 13. Birthplace \_\_\_\_\_

MOTHER 14. Maiden name Martha Sapp  
 15. Birthplace Balto.

16. Informant Mrs. Nellie E. Sambrill  
 Address 3 W. Summit Ave (Carney)

17. Burial Date thereof 3 16 46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Moreland Mem.Location Baltimore18. Funeral director Philip Herwig SonsAddress 2024 Orleans St

19. 3/1/4 19 46 A. W. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 13 19 46 at P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 14 19 46 to 3/17 19 46  
 and that I last saw him alive on 3/17 19 46

Immediate cause of death Myocardial infarction  
Hardening of  
Arteries  
High Blood Pressure  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

DURATION

1 day

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Dr. A. C. Hearn  
2901 Carroll Rd  
 Address \_\_\_\_\_ Date signed 3/14/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

02373 44  
Reg. Dist. No.

### 1. PLACE OF DEATH:

County Baltimore  
City or town Fort Howard, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 150 days  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp. Fort Howard, Md.  
How long in hospital or institution? 150 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2222 N. Calvert St.  
(If rural, give LOCATION)  
2(a) If veteran, name war WW-1

### 3. (a) FULL NAME

HENRY B. GARLAND

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
6. (b) Name of husband or wife single  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) December 15, 1886  
8. AGE: Years 59 Months 2 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
9. Birthplace Warsaw, Va.  
(Town, county, and state)  
10. Usual occupation Pressman  
11. Industry or business  
12. Name Moore B. Garland  
13. Birthplace Virginia  
14. Maiden name Sally Brent  
15. Birthplace Virginia

16. Informant Clinical Records Vets. Adm.  
Address Fort Howard, Maryland

17. Burial 3/9/46  
(Burial, cremation, or removal, which?) (month) (day) (year)  
Cemetery or crematory Lorraine  
Location Balto. Co. Md.

18. Funeral director William Cook Inc  
Address 1217 St. Paul St.

19. March 7 19 46 Geo H. Smith  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 6, 19 46, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 7 19 45, to March 6 19 46, and that I last saw him alive on March 6 19 46

Immediate cause of death  
Heart Disease - Hypertension and coronary arteriosclerosis, myo-xxx cardial insufficiency, auriculo-ventricular block, left bundle xxx branch block  
DURATION 9 mos.

Other conditions Bronehopneumonia, terminal Uremia, acute, terminal  
(Include pregnancy within 3 months of death)

Major findings of operations None  
Date of op. \_\_\_\_\_  
Autopsy results Above diagnoses confirmed by autopsy  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE A.M. BALTER, I.T. COL. M.C. CLIN. DIR.  
M. D. or other  
Address Fort Howard, Md. Date signed 3-6-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-E)

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 month, 6 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 1 month, 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 801 Washington Boulevard  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war no

## 3. (a) FULL NAME

Lillie Geers

## 3. (b) Social Security Number

-

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced separated  
 6. (b) Name of husband or wife Dewey Geers B. (c) If alive, give age sep. years  
 7. Birth date of deceased (mo., day, yr.) September 19, 1914  
 8. AGE: Years 31 Months 5 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Newport News, Virginia  
 (Town, county, and state)  
 10. Usual occupation none  
 11. Industry or business none  
 FATHER 12. Name George Melvin Strain  
 13. Birthplace Baltimore, Md.  
 MOTHER 14. Maiden name Mary Bailey  
 15. Birthplace Virginia

16. Informant Hospital Records  
 Address Baltimore-28, Md.  
 17. Burial Date thereof Mar 9, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory \_\_\_\_\_  
 Location Landon Park cemetery  
 18. Funeral director Joseph Farace Inc  
 Address 2013 Greenmount ave  
 19. March 7 19 46 Arthur J. [Signature]  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 19 46 at 9:00 a.m.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 31 19 46 to March 6 19 46  
 and that I last saw h. er alive on March 6 19 46

## Immediate cause of death

Jaundice due to therapeutic malaria

## DURATION

6 days

Due to

General ParesisIndef.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Isadore Tuerk  
Isadore Tuerk, M.D.  
Catonsville 28, Md. M. D. or otherAddress \_\_\_\_\_ Date signed 3/6/46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

02374

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Baltimore  
City or town Middle River - ro.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Carroll Island Road

How long in hospital or institution?

## 3. (a) FULL NAME

Louis George3. (b) Social Security Number  
None4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Carrie Miller George7. Birth date of deceased (mo., day, yr.) Mch 8 18638. AGE: Years 83 Months — Days 10 If less than one day  
..... hrs. .... min.9. Birthplace Baltimore City Md  
(Town, county, and state)10. Usual occupation At Home

11. Industry or business

12. Name Conrad George13. Birthplace Germany14. Maiden name Catherine Hessler15. Birthplace Germany16. Informant Mrs Louis G DavisAddress Carroll Island Rd Box 338 R 1417. Burial Date thereof Mch 20 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Sacred HeartLocation German Hill Road18. Funeral director Lassahn Funeral HomeAddress 7401 Belair Road19. 3/18 19 46 John G. Gueley  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County Baltimore  
City or town Middle River - ro -  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Carroll Island Road  
(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 19 46 at 8:20 a. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
..... 19..... to ..... 19.....

and that I last saw him ..... alive on ..... 19.....

Immediate cause of death Coronary Occlusion

DURATION

Due to A-S-C-V-Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE M B Davis M.D.Address 1111 Med. Exam. Bldg. M.D. or other  
Quincy St. Baltimore Date signed 3/18/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 22 1946  
BUREAU V. B.



# MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore

Reg. Dist. No. \_\_\_\_\_

## CERTIFICATE OF DEATH

02276

1. PLACE OF DEATH Baltimore  
 (a) County Baltimore  
 (b) City or town Reisterstown  
 (If outside city or town limits, write RURAL and give town)  
 (c) Street address, hospital, or institution Mt. Pleasant Sanatorium  
 (d) Length of stay in hospital or inst. (yrs., mos., or days) Feb 6, 1946  
 (e) Length of stay in this community (yrs., mos., or days) \_\_\_\_\_

2. HOME (USUAL RESIDENCE) OF DECEASED:  
 (a) State Md (b) County Maryland  
 (c) City or town Baltimore  
 (If outside city or town limits, write RURAL and give town)  
 (d) Street No. 6 North Front St.  
 (If rural give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years

3 (a) FULL NAME MARY GREENBERG

3 (b) If veteran, name war \_\_\_\_\_ 3 (c) Social Security No. 214-01-6374

4. Sex Female 5. Color or race White 6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife \_\_\_\_\_ 6 (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) May 6, 1914  
 8. AGE: Years 31 Months 10 Days 23 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Baltimore, Md  
 (Town, county, and state)

10. Usual occupation Typist

11. Industry or business \_\_\_\_\_

MOTHER FATHER  
 12. Name Rubin Greenberg  
 13. Birthplace Russia  
 14. Maiden Name Sarah Cohen  
 15. Birthplace Russia

16 (a) Informant Father  
 (b) Address \_\_\_\_\_

17 (a) Burial (b) Date thereof 3-31-46  
 (Burial, cremation, or removal) (month) (day) (year)  
 (c) Cemetery or crematory Rosedale  
 Location Ph & Rd. of Hamilton Ave

18 (a) Funeral director Jack Levy Inc  
 (b) Address 1438 E. Baltimore St

19 (a) 3/30/46 (b) City Health Dept.  
 (Date rec'd by registrar) (Registrar)

### MEDICAL CERTIFICATION

20. Date of death March 29 19 46, at 8 55 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 6 19 46, to March 29 19 46, and that I last saw him alive on March 29 19 46.

Immediate cause of death \_\_\_\_\_ Duration \_\_\_\_\_

For advanced Pulmonary Tuberculosis  
 Due to \_\_\_\_\_ 10 months

Due to Myocardial Collapse

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings:  
 Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

### PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? \_\_\_\_\_ While at work? \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

23. Signature Albert F. Shrier

M. D. or other

Address 6118 Park Heights Ave Date signed March 29, 1946

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
APR 1 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (181)

## CERTIFICATE OF DEATH

02377

Reg. Dist. No. 74

## 1. PLACE OF DEATH:

County Balto  
City or town Chase  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto  
City or town Chase  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Wansley Pt. Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name was

## 3. (a) FULL NAME

Engine Griffin

## 3. (b) Social Security Number

4. Sex M 5. Color or race Colored 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife Ellen Griffin7. Birth date of deceased (mo., day, yr.) Jan. 5 - 1879 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 67 Months \_\_\_\_\_ Days 24 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Balto. Co.  
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

12. Name Mr. Henry Griffin13. Birthplace Chase, Md.14. Maiden name Unknown

15. Birthplace \_\_\_\_\_

16. Informant Susie GriffinAddress Chase, Md.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 3 12 46  
(month) (day) (year)Cemetery or crematory Sharp St.Location Chase, Md.18. Funeral director Mrs. R. Q. Elliott & daughterAddress 1129 N. Caroline St.19. 63-11 19 46 John D. Donnelly  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3-9 19 46 at 9:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_

DURATION

Shock due toDue to 3rd degree burnsDue to over entire body

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 3/9/46Where did injury occur? Chase, Balto. Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Campylobacter Injured at work? \_\_\_\_\_23. SIGNATURE W. B. Davies M. D.  
M. D. or other \_\_\_\_\_Address Donalck Md Date signed 3/9/46

RECEIVED

MAR 22 1946

BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 90 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Ft. Howard, Md.How long in hospital or institution? 90 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1011 West 38th St.  
(If rural, give LOCATION)2.(a) If veteran, name war SAW

## 3. (a) FULL NAME

HARRY W. HAGER

## 3. (b) Social Security Number

213-20-8584 A

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Male</u>	<u>White</u>	<u>Married</u>

6. (b) Name of husband or wife Hattie G. Hager6. (c) If alive, give age 67 years7. Birth date of deceased (mo., day, yr.) 5-10-76

8. AGE:	Years	Months	Days	If less than one day
	<u>69</u>	<u>10</u>	<u>8</u>	.....hrs. ....min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)10. Usual occupation Carpenter

11. Industry or business

12. Name George P. Hager13. Birthplace Maryland14. Maiden name Laura Boring15. Birthplace Maryland16. Informant Clinical Records, Vets. Adm. HospitalAddress Ft. Howard, Md.17. Burial Date thereof March 21-1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director Burgee Funeral HomeAddress 3631 Falls Rd., Balto., Md.19. 3-20 46 CW Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 18, 1946 at 7:10 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 18, 1946 to March 18, 1946and that I last saw him alive on March 18, 1946Immediate cause of death Pulmonary infarct right DURATION 3 DaysDue to Disease of the heart-- 12-18-45  
Arteriosclerosis, Aortic stenosis, Plus  
Cardiac enlargement, Mitral Insufficiency  
(Relative) Myocardial Insufficiency  
Class IV

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. M. BALTER, LT. COL., M.D.Address Fort Howard, Maryland Date signed 3-19-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

## CERTIFICATE OF DEATH

Reg. Diat. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Mount Wilson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 0 yrs., 11 mos., 12 days  
 Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium  
 How long in hospital or institution? 0 yrs., 11 mos., 12 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 38 E. 26th Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Joseph N. Hale

## 3. (b) Social Security Number

217-01-2269

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Joan Q. Hale6.(c) If alive, give age 45 years7. Birth date of deceased (mo., day, yr.) January 18, 1903

8. AGE: Years 43 Months 1 Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Carroll Co., Maryland  
(Town, county, and state)10. Usual occupation Shipping Clerk

11. Industry or business \_\_\_\_\_

12. Name Caleb D. Hale13. Birthplace Baltimore Co., Maryland14. Maiden name Mary E. Brown15. Birthplace Howard Co., Maryland18. Informant Joseph HaleAddress 38 E. 26th St., Balto., Md.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof March 5, 1946  
(month) (day) (year)Cemetery or crematory Greenmount CemeteryLocation North Ave. & Greenmount St.18. Funeral director William Tickner & SonsAddress Pa. and North Avenues19. March 2, 1946 (Date rec'd by registrar)Registrar Earl Y. Webster

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1946 at 10:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18, 1945 to March 2, 1946 and that I last saw him alive on March 2, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 18 Mos.

Due to Tubercle Bacilli

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Date of op. \_\_\_\_\_

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Stewart S. Shaffer M.D.

M. D. or other \_\_\_\_\_

Address Mount Wilson, Md. Date signed 3/12/46Rec'd 3-6-46

RECEIVED

MAR 6 1946

BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 33-

1. PLACE OF DEATH: Baltimore.  
 County.....  
 City or town Rural near Freeland.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 26 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Rural near Freeland.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. at Ruhls, Md.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3.(a) FULL NAME John Nelson Hare.

3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed.  
 6.(b) Name of husband or wife Matilda Hare.  
 7. Birth date of deceased (mo., day, yr.) October 29, 1853.  
 6.(c) If alive, give age..... years  
 8. AGE: Years 92 Months 4 Days 9. If less than one day..... hrs. .... min.

9. Birthplace Millers, Md. R.D.  
 (Town, county, and state)  
 10. Usual occupation Carpenter.  
 11. Industry or business Self.  
 12. Name John Henry Hare.  
 13. Birthplace Maryland.  
 14. Maiden name Hampsher.  
 15. Birthplace Maryland.

16. Informant Mrs. James Zimmerman  
 Address Freeland, Md.  
 17. Burial Date thereof March 11, 1946.  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. Paul & B. Cemetery  
 Location Millers, Md. R.D.  
 18. Funeral director Isaac Hartenstein  
 Address New Freedom, Pa.

19. Mar 9 19 46 Charles L. Pullin  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 8, 19 46 at 12:30 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 1 19 46 to Mar. 8 19 46  
 and that I last saw him alive on Mar. 6 19 46  
 Immediate cause of death Chronic myocarditis  
 DURATION  
 Due to.....  
 Due to.....  
 Other conditions generalized arteriosclerosis  
 (Include pregnancy within 3 months of death)  
 Major findings of operativus.....  
 Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?.....

23. SIGNATURE G. M. France M. D. or other  
Parlinton, Md. Date signed 3/9/46  
 Address.....



RECEIVED  
MAR 27 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1862)

## CERTIFICATE OF DEATH

Reg. Dist. No. 031058

## 1. PLACE OF DEATH:

County BALTIMORECity or town TOWSON  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 yrs; 9 mos; 19 das.Hospital, institution, or street address where death occurred:  
SHEPPARD AND ENOCH PRATT HOSPITALHow long to hospital or institution? 8 yrs; 9 mos; 19 das.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Columbia County WashingtonCity or town Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 727 Webster St. N. W.  
(If rural, give LOCATION)2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

LEE CARROLL HAYDN

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

6. (c) If alive, give age years7. Birth date of deceased (mo., day, yr.) October 7, 18798. AGE: Years 66 Months 5 Days 23 If less than one day hrs. mto.9. Birthplace Leonardtown, Maryland  
(Town, county, and state)10. Usual occupation Commercial Representative11. Industry or business Potomac Telephone Co.12. Name William H. Hayden13. Birthplace Maryland14. Maiden name Sarah Anne Delahay15. Birthplace Maryland16. Informant HOSPITAL RECORDS

Address

17. Burial Date thereof April 1, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rock Creek CemeteryLocation Washington, D. C.18. Funeral director Francis J. CollinsAddress 3821-14th St. N.W. Wash. D.C.19. 8/30 19 46 G. W. Baer  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 30 19 46 at 3:55 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 11 19 37 to March 30 19 46and that I last saw him alive on March 30 19 46Immediate cause of death Broncho pneumonia and hemorrhagic infarction of the lung & emphysema

DURATION

3 daysDue to Coronary sclerosisHeartDue to Fracture of left hip due to accidental fallOther conditions Manic depressive depressed9 yr +Fracture left hip  
(Include pregnancy within 3 months of death)3/4/46

Major findings of operations

Date of op.

Autopsy results Confirms above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date March 30, 1946Where did injury occur? Sheppard & Enoch Pratt Hospital  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. W. Elgin M. D. or otherAddress TOWSON, MD. Date signed 3/30/46

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
APR 1 1946  
BUREAU V.8

RECEIVED MAY 21 1946

N. B.--Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

Village or City Turner's Station (No. 114 Cherry Lane St. 41 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME John W. Hebron

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE C 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single (Write the word)

6 DATE OF BIRTH 11 - 18, 1899  
(Month) (Day) (Year)

7 AGE 46 yrs. 3 mos. 17 ds. or 1 day 1 hrs. 1 min. 5 If LESS than

8 OCCUPATION  
(a) Trade, profession or particular kind of work Cook's Helper  
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country) Annapolis Md.

10 NAME OF FATHER Fredrick Hebron

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary J. Johnson

13 BIRTHPLACE OF MOTHER (State or Country) Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fredrick Hebron

(Address) 707 I St. Sparrows Pt.

15 Filed 3/8/46 1942 J. W. Hebron Registrar

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 41

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Mar. 6, 1946  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from 192 to 192, that I last saw him alive on 192, and that death occurred on the date stated above, at m.

The CAUSE OF DEATH \* was as follows:

Fracture Skull, rt. clavicle  
& left jaw bone, pelvis.  
Right chest crushed &  
dislocation at hip. (Duration) etc. mos. ds.

Contributory  
Secondary

Hit by street car (Duration) etc. yrs. mos. ds.  
(Signed) W. H. Barre M. D.  
3/6/46 (Address) W. H. Barre

\*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death etc. yrs. mos. ds. In the State etc. yrs. mos. ds.

Where was disease contracted, if not at place of death? etc.

Former or usual residence etc.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Balta National Cem Mar. 11, 1946

20 UNDERTAKER ADDRESS

Saml. W. Chase & Son 638A E. Howard St.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

(Approved by U. S. Census and American Public  
Health Association.)

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school*, or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia,"

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unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonaeum*, etc., *Carcinoma, Sarcoma*, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. FOR VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Edgemere

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Edgemere

(If outside city or town limits, write RURAL and give nearest town)

Street No. Bethlehem Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Ada B. Herndon

## 3. (b) Social Security Number

none

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Widow</u>
-------------------------	----------------------------------	--

6. (b) Name of husband or wife Philip Herndon

8. (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 24, 1883

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>7</u>	<u>28</u>	..... hrs. .... min.

9. Birthplace Orange Va.  
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Jaret Amos13. Birthplace Va.14. Maiden name Martha F.--15. Birthplace Va.16. Informant Mr. Granville AmosAddress Bethlehem Ave.17. Removal Date thereof March 23 / 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Orange Cem.Location Orange Va.18. Funeral director Philip Herndon SonsAddress 2024 Orleans St.19. 3/23/ 46 A. W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 22, 1946 19..... at..... M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21 46 to Mar 22 19 46 and that I last saw him alive on Mar 22 19 46Immediate cause of death Pulmonary edema. DURATION 4 hours.Due to myocardial failure - 4 hours.Due to Lobar. Pneumonia. 5 days.

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Louis J. Pollin M.D. M. D. of otherSpawrous, Print. Md. Date signed 3-22-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 897

## CERTIFICATE OF DEATH

02383

Reg. Dist. No. 35

## 1. PLACE OF DEATH:

County BaltimoreCity or town White Hall  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County White HallCity or town White Hall  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

THOMAS F. HINES

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife \_\_\_\_\_

8.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Oct 1 - 18628. AGE: Years 83 Months 5 Days 5 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.8. Birthplace Baltimore, Md  
(Town, county, and state)10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

12. Name Martin Hines13. Birthplace Ireland14. Maiden name Ann C. Toole15. Birthplace Ireland16. Informant Frank HinesAddress Baltimore, Md17. Buried Date thereof 3/9/46  
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory St. Peter'sLocation Baltimore, Md18. Funeral director F. B. Wierzbicki, SonAddress 1300 Eastern Place19. March 6 19 46 Mrs. Howard S. Markline  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH MARCH 6 19 46 at 6:12 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 19 46 to MARCH 6 19 46and that I last saw him alive on MARCH 19 46Immediate cause of death Cerebral Thrombosis

DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. L. France  
M. D. or other \_\_\_\_\_Address Parleton, Md. Date signed 3/1/46



CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BIRTH

10. DATE OF BIRTH

11. MARITAL STATUS

12. EDUCATION

13. RELIGION

14. RACE

15. PREVIOUS ILLNESS

16. MEDICAL HISTORY

17. SIGNATURE OF PHYSICIAN

18. SIGNATURE OF REGISTRAR

19. SIGNATURE OF WITNESSES

20. SIGNATURE OF DECEASED

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 02381 38

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 28 years, 3 mos., 19 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 28 years, 3 mos., 19 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 603 East Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

John P. Hoff

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Amelia Hoff 6.(c) If alive, give age 7 years  
 7. Birth date of deceased (mo., day, yr.) June 26, 1866  
 8. AGE: Years 79 Months 8 Days 7 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Switzerland  
 (Town, county, and state)  
 10. Usual occupation Carpenter  
 11. Industry or business Carpentry  
 FATHER 12. Name John E. Hoff  
 13. Birthplace Switzerland  
 MOTHER 14. Maiden name Mary Cum  
 15. Birthplace Switzerland

16. Informant Hospital records  
 Address Catonsville-28, Maryland  
 17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/7/46  
 (month) (day) (year)  
 Cemetery or crematory Holy Cross  
 Location Catonsville  
 18. Funeral director William Prof. J. J. J.  
 Address 1219 St. Paul St.  
 19. 3/6 46 A.W. Hedrick  
 (Date Rec'd by Registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 1946 at 12:20 a.m.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
November 14 1917 to March 5 1946  
 and that I last saw him alive on March 5 1946

Immediate cause of death Miliary tuberculosis, both lungs  
 DURATION Approx. 6 weeks  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Generalized arteriosclerosis -  
Indefinite  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results As above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Isadore Tuerk, M.D.  
 Address Catonsville-28, Md. Date signed 3-5-46  
 M. D. or other \_\_\_\_\_

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and fully.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

## CERTIFICATE OF DEATH

02385

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hood's Nursing Home, Edmondson Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 110 S. Rolling Rd.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Annie I. Hood

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife

Late Wm. W. Hood

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Feb. 28, 1868.

8. AGE:

Years

78

Months

Days

4

If less than one day

.....hrs. ....min.

9. Birthplace

Baltimore, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name James McGree13. Birthplace Baltimore, Md.14. Maiden name Unknown15. Birthplace Md.16. Informant Mrs. George Frey (Daughter.)Address 110 S. Rolling Rd. Catonsville

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof March 7/46  
(month) (day) (year)

Cemetery or crematory

Loudon Pk.

Location

3801 Frederick Rd.

18. Funeral director

Address

4101 Edmondson Ave.19. 3-7 - 46  
(Date rec'd by registrar)Harry H. Miller  
Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March - 4 19 46, at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov - 27 19 41 to March - 4 19 46  
and that I last saw her alive on March - 2 19 46

Immediate cause of death

Arterial Hypertension  
Cerebral Hemorrhage  
Anterior - Sclerosis

DURATION

5 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

J. Lloyd Johnson  
M. D. or other  
Address Catonsville, Md Date signed 3-5-46

845

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N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

02:86

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## 1. PLACE OF DEATH

County BaltimoreVillage or City CatonsvilleRegistration Dist. No. 36No. 15 Overbrook RoadSt. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 60 yrs. 00 mos. 00 ds. How long in U.S. if of foreign birth? 00 yrs. 00 mos. 00 ds.2. FULL NAME Thomas J. HoodIf U. S. Veteran, specify WAR WAR(a) Residence: No. 15 Overbrook RoadSt. Ward

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

## 3. SEX

male

## 4. COLOR OR RACE

white5. SINGLE, MARRIED, WIDOWED,  
OR DIVORCED (write the word)  
married5a. If married, widowed, or divorced  
HUSBAND of  
(or) WIFE ofMuriel Arnold6. DATE OF BIRTH (month, day, and year) March 27, 1860

## 7. AGE

Years 85Months 11Days 12If LESS than  
1 day, 00 hrs.  
or 00 min.

## OCCUPATION

8. Trade, profession, or particular  
kind of work done, as SPINNER,  
SAWYER, BOOKKEEPER, etc.police officer9. Industry or business in which  
work was done, as SILK MILL,  
SAW MILL, BANK, etc.retired10. Date deceased last worked at  
this occupation (month and  
year) 00 0011. Total time (years)  
spent in this  
occupation 00 0012. BIRTHPLACE (city or town) Harford County, Md.  
(State or country)

## FATHER

13. NAME John Hood14. BIRTHPLACE (city or town) Md.  
(State or country)

## MOTHER

15. MAIDEN NAME Alverta ?16. BIRTHPLACE (city or town) Md.  
(State or country)17. INFORMANT Mrs. Murel Arnold Hood  
(Address) 15 Overbrook Road, Catonsville

## 18. BURIAL, CREMATION, OR REMOVAL

Place Loudon Park Cem. Date March 12, 194619. UNDERTAKER John O. Mitchell & Sons, Inc.  
(Address) 1900 Eutaw Place, Baltimore20. FILED 3/12, 19 46 A. W. Hedrick  
Registrar

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

March 9

(Month)

(Day)

1946  
(Year)

## 22. I HEREBY CERTIFY, That I attended deceased from

1940 to March 9, 1946I last saw him alive on Feb 20, 1946; death is saidto have occurred on the date stated above, at P m.The PRINCIPAL CAUSE OF DEATH and related causes of importance  
were as follows:Hyperthyroidism  
secondary infection

Date of onset

24/2

Other Contributory Causes of importance:

Uremia?Name of operation 00 Date of 00What test confirmed diagnosis? 00 Was there an autopsy? 00

## 23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? 00 Date of Injury 00, 1900Where did injury occur? 00

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury 00Nature of injury 0024. Was disease or injury in any way related to occupation of deceased? NOIf so, specify 00(Signed) J. J. J. J. J.

M. D.

(Address) 723 Medical Arts Bldg., Baltimore

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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Example II

The principal cause of death and related causes of importance were as follows:

<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

Reg. Dist. No. 02387 44

### 1. PLACE OF DEATH:

County Baltimore  
City or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 6 Days  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp., Fort Howard, Maryland  
How long in hospital or institution? 6 Days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel Co.  
City or town Ferndale  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Vista Avenue  
(If rural, give LOCATION)  
2.(a) If veteran, name war SAW

### 3.(a) FULL NAME

WILLIAM J. HOY

### 3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Elizabeth A. Hoy 6.(c) If alive, give age 56 years  
7. Birth date of deceased (mo., day, yr.) 12-25-84  
8. AGE: 61 Years 2 Months 25 Days If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
9. Birthplace Baltimore, Maryland  
(Town, county, and state)  
10. Usual occupation Unemployed  
11. Industry or business  
12. Name John M. Hoy  
13. Birthplace Maryland Ireland  
14. Maiden name Harriet Elserode  
15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.  
Address Ft. Howard, Maryland

17. Burial Date thereof March 26, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Baltimore National  
Location Baltimore, Md  
18. Funeral director Thomas W. Brighton  
Address Blew Burnis, Md.

19. 3/25 1946 Lawrence L. Farber  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1946 at 11:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17, 1946 to March 23, 1946 and that I last saw him in alive on March 23, 1946

Immediate cause of death Bilateral Broncho-pneumonia

DURATION

6 Days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Cardiac Failure

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE A. M. BALTER  
A. M. BALTER, LT. COL., M.C. MCLEIN, DIR.  
Address Fort Howard, Md. Date signed 3-23-46

MARGIN RESERVED FOR BINDING

VS A15

945-115M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 19 years 20 days

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 19 years 20 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Parkville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Anna Hundertmark

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white widowed6. (b) Name of husband or wife Fred. Hundertmark

B. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 18868. AGE: Years 59 Months 6 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name George Bauernsuff13. Birthplace Germany14. Maiden name Ida May Stivers15. Birthplace Germany16. Informant Spring Grove State Hosp. RecordsAddress Catonsville 28, Maryland17. Burial Date thereof 4/3/46  
(Burial, cremation, or funeral home) (month) (day) (year)Cemetery or crematory WoodlawnLocation " Md.18. Funeral director William Cook Inc.Address 1217 St. Paul St.19. 4/6 46 A.W. Hedrick  
(Date) (Age) (Signature)

(Date) (Age) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 19 46 at 10.40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 5 19 27 to March 31 19 46and that I last saw her alive on March 31 19 46

Immediate cause of death:

Chronic Myocarditis

DURATION

Indef.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Ischemic Heart, M.D.

23. SIGNATURE \_\_\_\_\_ M. D. or other

Address Spring Grove State Hosp. Date signed March 31 19 46

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02389

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred:

Veterans Hosp., Fort Howard, Md.How long in hospital or institution? 3 weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Havre de Grace  
(If outside city or town limits, write RURAL and give nearest town)Street No. 712 Revolution St.  
(If rural, give LOCATION)2. (a) If veteran, name war World War I

## 3. (a) FULL NAME

Arthur Franklyn Hunter

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Mrs. Sarah HunterB. (c) If alive, give age 45 years7. Birth date of deceased (mo., day, yr.) January 24, 18968. AGE: Years 50 Months 1 Days 9 If less than one day  
hrs. min.9. Birthplace Williamsburg, Ky.  
(Town, county, and state)10. Usual occupation unemployed

## 11. Industry or business

FATHER 12. Name William Hunter13. Birthplace KentuckyMOTHER 14. Maiden name Elizabeth Thompson15. Birthplace Kentucky16. Informant Hospital records

Address

17. burial Date thereof Mar. 8, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Angel HillLocation Havre de Grace, Md.18. Funeral director R. Madison MitchellAddress R. Madison Mitchell  
Havre de Grace, Md.19. March 6 19 46 John H. Donnelly  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 5, 1946 at 8:55 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
February 2, 1946 to March 5, 1946  
and that I last saw him alive on March 5, 1946Immediate cause of death Bronchopneumonia DURATION 7 days

Due to

Due to

Other conditions Strictures, urethral 9 years  
Spondylitis, Marie-Strumpel type unknown  
(Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. Kurnitz, M.D. M. D. or otherAddress Veterans Hospital, Fort Howard, Md. Date signed March 6, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 12 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 weeks  
 Hospital, institution, or street address where death occurred:  
Veterans Hosp., Fort Howard, Md.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Harford  
 City or town Havre de Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 712 Revolution St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war World War I

## 3. (a) FULL NAME

Arthur Franklyn Hunter

## 3. (b) Social Security Number

none

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mrs. Sarah Hunter  
 6. (c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) Jan 24, 1896

8. AGE: Years 50 Months 1 Days 9 If less than one day  
 hrs. min.

9. Birthplace Williamsburg, Ky.  
 (Town, county and state)

10. Usual occupation unemployed

11. Industry or business

12. Name William Hunter

13. Birthplace Kentucky

14. Maiden name Elizabeth Thompson

15. Birthplace Kentucky

16. Informant Hospital records

Address

17. Burial Date thereof Mar. 8, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Angel Hill

Location Havre de Grace, Md.

18. Funeral director R. Madison Mitchell

Address Havre de Grace, Md.

19. March 6 46 John B. Cunnelly  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 5 19 46 at 8:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 2 19 46 to March 5 19 46  
 and that I last saw him alive on March 5 19 46

Immediate cause of death Bronchopneumonia DURATION 7 days

Due to

Due to

Other conditions Structures, urethral 9 years  
spondylitis, main. Strump type unknown  
 (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. Hunnity, M.D. M. D. or other

Address Veterans Hospital, Fort Howard, Md. Date signed March 6, 1946

RECEIVED

MAR 22 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

02390

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

6817 Dunhill Rd.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 6817 Dunhill Rd.  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Glenna B. Hussey

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

H. Edward Hussey

7. Birth date of deceased (mo., day, yr.)

June 14 - 1911

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

34

hrs. min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

3/8/46

Cemetery or crematorium

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

46

A. W. Hedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 - 1946, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1939 to March 6 1946  
 and that I last saw him alive on Feb 24 1946

Immediate cause of death

DURATION

Pulmonary Tuberculosis 12 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. W. Jacobsen M. D. or other  
 Address 2300 Eutaw Place Date signed 3-8-46





## INSTRUCTIONS FOR MEDICAL CERTIFICATION

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### WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

### DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

### DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

### DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

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For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-1

## CERTIFICATE OF DEATH

Reg. Dist. No. 02392 44

## I. PLACE OF DEATH:

County Baltimore  
 City or town Sparrow Pt.  
 (If outside city or town limits, write RURAL NEAR and give town)  
 Street address, hospital, or institution 1006 F. St.  
 Stay in hospital or inst. (yrs., or mos., or days) \_\_\_\_\_  
 Stay in this community (yrs., or mos., or days) \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Balto.  
 City or town Sparrow Pt. Ward No. \_\_\_\_\_  
 (If outside city or town limits, write RURAL NEAR and give town)  
 Street No. 1006 F. St.  
 (If rural give LOCATION)

## 2(c) IF VETERAN, NAME WAR \_\_\_\_\_

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Kathleen

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Sept. 12 - 1867

8. AGE: Years 78 Months 5 Days 20 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Penna.  
(Town, county, and state)10. Usual occupation Retired

11. Industry or business \_\_\_\_\_

12. Name Henry Jeffries

13. Birthplace \_\_\_\_\_

14. Maiden name Elizabeth Sillescu15. Birthplace Penna.16. Informant Kathleen JeffriesAddress 1006 F. St.17. Burial Date thereof 3/8/46  
(Burial, cremation, or removal: Which? (month) (day) (year))Cemetery or crematory Westminster LawnLocation Phila. Pa.18. Funeral director John A. MoranAddress 3070 E. Balto. St.19. Mar 7 19 46 D. T. Harbin  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 - 19 46 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 19 46, to March 4 19 46,  
 and that I last saw him alive on March 4 19 46.

## Immediate cause of death

Cerebral ThrombosisDue to Arteriosclerotic Heart Disease

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

## DURATION

4 days

## PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE Dr. J. P. ...

M. D. or other \_\_\_\_\_

Address 525 D St. S.W. Date signed 3-5-46

RECEIVED

MAR 9 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-0)

## CERTIFICATE OF DEATH

02393

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred:

Woods Convalescent HomeHow long in hospital or institution? 3 weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Rock Hall  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mary Alice Jones

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Nov. 5, 18688. AGE: Years Months Days If less than one day  
77 4 5 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Baltimore, Maryland  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Charles C. Shelby13. Birthplace Baltimore, Md.14. Maiden name Mary E. Andrews15. Birthplace Alexandria, Va.16. Informant Salmon J. JonesAddress Rock Hall, Maryland17. Burial Date thereof March 4, 1946  
(Burial, cremation, or removal. Which) (month) (day) (year)Cemetery or crematory Shelby Burial Place

Location \_\_\_\_\_

18. Funeral director Edgar L. LaneAddress Church Hill, Md.19. 3-2- 19 46 Shirley D. Miller  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 1 19 46 at 4A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10 19 46 to Mar 1 19 46and that I last saw h. \_\_\_\_\_ alive on Feb 28 19 46Immediate cause of death Cor. Myocard Infarct DURATION 3 monDue to Generalized ArteriosclerosisDue to SclerosisOther conditions Fatigue of Eye 6 mon

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

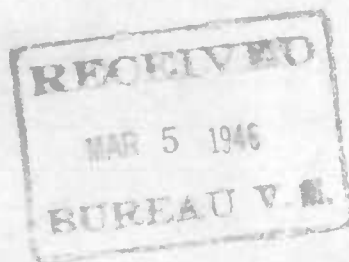
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where)? \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE James H. Jones M. D. or otherAddress Rock Hall, Md. Date signed 3-1





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93-d)

## CERTIFICATE OF DEATH

13402394

Reg. Dist. No. 30

### 1. PLACE OF DEATH:

County Baltimore

City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs., 11 mos., 23 days

Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital

How long in hospital or institution? 15 yrs., 11 mos., 23 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 11 North Exeter Street  
(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (a) FULL NAME

Demetrias Kalanaack

### 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1884

8. AGE: Years Months Days If less than one day  
62 ? ? hrs. min.

9. Birthplace Greece  
(Town, county, and state)

10. Usual occupation Dish-washer

11. Industry or business Belvedere Hotel

12. Name ?

13. Birthplace ?

14. Maiden name ?

15. Birthplace ?

16. Informant Hospital records

Address Catonsville-28, Maryland

17. Burial Date thereof 4-5-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Spring Grove State Hospital

Location Catonsville 28, Maryland

18. Funeral director Spring Grove State Hospital

Address Catonsville 28, Maryland

19. 4-5 46

(Date rec'd by registrar) 19. 46

Harrell Miller Deputy Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 19. 46 at 9:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him alive on.....19.....

Immediate cause of death

DURATION

Acute Cardiac failure

Due to

Cardiovascular disease

Due to

Sudden death

Other conditions engaging

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geoff M. Kieffer MD

M. D. or other

Address 1010 Leake and Date signed 3-27-46

MARGIN RESERVED FOR BINDING

I

9.45-15M

V8 A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED  
APR 8 1946  
BUREAU 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Hd)

## CERTIFICATE OF DEATH

02395

Reg. Diat. No. 40

## 1. PLACE OF DEATH:

County BaltimoreCity or town Notch Cliff near Towson  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town Notch Cliff near Towson  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Sister Mary Titus Kellepy

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

B. (c) if alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Feb. 17-1880

8. AGE: Years Months Days If less than one day

661-

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace East Cambridge Mass  
(Town, county, and state)10. Usual occupation Teacher

11. Industry or business

FATHER 12. Name James Kelley13. Birthplace Bandon IrelandMOTHER 14. Maiden name Mary Morrison15. Birthplace Castlewarrys, Ireland18. Informant Sr. Mary clareAddress Notch Cliff, Md17. Burial Date thereof Mar. 19/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Notch CliffLocation Gen Arm18. Funeral director Rev. M. G. F. 16 SonAddress 811 N. 16th St. Baltimore19. 3/18/46 19 \_\_\_\_\_  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 19 46 at 12.20 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Sept. 19 19 45 to March 17 19 46and that I last saw her alive on March 17 19 46Immediate cause of death Coronary occlusion

DURATION

sudden

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Thos. Green

M. D. or other

Address 1601 N. 16th St. Baltimore Date signed Mar 17/46

RECEIVED  
MAR 22 1946  
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02396 38

Reg. Dist. No. ....

1. PLACE OF DEATH: *Hospital for Consumptives, Maryland.*County *Eudowood-Sauw. Termon Balt. Co.*City or town *Toxson, Md.*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County .....City or town *Sat Pleasant Ind.*  
(If outside city or town limits, write RURAL and give nearest town)Street No. *6911. Linwood Md.*  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME

*James Helso*

3. (b) Social Security Number

4. Sex *m* 5. Color or race *w* 6. (a) Single, married, widowed, or divorced *infant*

6. (b) Name of husband or wife .....

7. Birth date of

deceased (mo., day, yr.)

*August 17, 1944.*

6. (c) If alive, give age .....

8. AGE:

Years

Months

Days

If less than one day

*1**197*

.....hrs.

.....min.

9. Birthplace *Cheverly Md.*

(Town, county, and state)

10. Usual occupation .....

11. Industry or business .....

FATHER

12. Name *Samuel Helso*13. Birthplace *Penna.*

MOTHER

14. Maiden name *Marian Marguaret*15. Birthplace *Md. Penna.*16. Informant *Dean Marguaret*Address *Rogersstown, Md.*

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

*Mar. 19, 1946*Cemetery or crematory *St. Rose's*Location *Hagerstown, Md. Pa.*18. Funeral director *A. R. Colquhoun*Address *Rogersstown, Md.*19. *March 18*

(Date rec'd by registrar)

19 *46*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *March 17* 19 *46* at *1:00* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Feb 13* 19 *46* to *March 17* 19 *46*and that I last saw him alive on *March 17* 19 *46*

Immediate cause of death .....

DURATION

Due to *military Tb.* *unknown*

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide .....

Where did injury occur? .....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury .....

Injured at work?

23. SIGNATURE *G. H. Tuckelstein M.D.*

M. D. or other

Address *Eudowood-Towson Md.* Date signed *Mar. 17, 1946*

RECEIVED  
APR 2 1946  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6472)

## CERTIFICATE OF DEATH

Reg. Dist. No. 02397 35

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Buylon  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 19 years  
 Hospital, institution, or street address where death occurred: Home  
 How long in hospital or institution? at home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)  
 State Md. County Ballo.  
 City or town Buylon  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Berwick Rd.  
 (If rural, give LOCATION)  
 2.(a) if veteran, name war

## 3. (a) FULL NAME

Ellen Margaret Kennedy

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Alex. D. Kennedy  
 6. (c) If alive, give age 45 years  
 7. Birth date of deceased (mo., day, yr.) March-9-1897  
 8. AGE: Years 49 Months 0 Days 5 If less than one day, hrs. min.  
 9. Birthplace Marnekerle, Minn.  
 (Town, county, and state)  
 10. Usual occupation Housewife

## 11. Industry or business

FATHER 12. Name Charles Tremper  
 13. Birthplace Ohio  
 MOTHER 14. Maiden name Nellie Dilg  
 15. Birthplace Prima

16. Informant A. D. Kennedy (husband)  
 Address Buylon Md.

17. Burial, cremation, or removal, Which? Burial Date thereof 3-18-46  
 (month) (day) (year)  
 Cemetery or crematory Mt. Maria - (Imm. Reception Church)  
 Location Towson Md.

18. Funeral director STEWART & HOWELL COMPANY  
 Address (W. F. WOODEN BLDG.) 100 E. NORTH AVENUE

19. 3/16 19 46 A.W. Hedrich  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 19 46 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

home 19 46, to 19  
 and that I last saw him alive on 19

Immediate cause of death Strangulation by hanging - suicideDue to Menopausal Depression

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 3/14/46Where did injury occur? Home Buylon Baltimore Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Suicide - hanging Injured at work?23. SIGNATURE Rollin C. Hudson M.D.Address Towson 4 Md. Date signed 3/14/46

M. D. or other

Rec'd VS  
3/16/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02398

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County BaltimoreCity or town Pikesville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Life

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Pikesville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 213 Church Lane  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

1867

6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

79

hrs. min.

## 9. Birthplace

## 10. Usual occupation

## 11. Industry or business

FATHER

## 12. Name

## 13. Birthplace

## MOTHER

## 14. Maiden name

## 15. Birthplace

## 16. Informant

## Address

## 17. Burial

(Burial, cremation, or removal, which?)

## Date thereof

(month) (day) (year)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19. Date rec'd by registrar

March 25, 1946

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1946 at 6:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

several years to March 24 1946and that I last saw him alive on March 23 1946

Immediate cause of death

DURATION

Chronic MyocarditisArterio Sclerosis

Due to

Due to

Other conditions

Carcinoma of bladder - 1 1/2 yrsScrub typhus

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE E E Nichols MD

M. D. or other

Address Alexandria, Va. Date signed March 28, 46

RECEIVED  
MAR 27 1946  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 937

## CERTIFICATE OF DEATH

02399

Reg. Dist. No. 32

1. PLACE OF DEATH: **Baltimore**  
 County.....**Pikesville**  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
**Augsburg Home**  
 How long in hospital or institution? **5 Yrs.**

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....**Md** County.....**Baltimore**  
 City or town.....**Pikesville**  
 (If outside city or town limits, write RURAL and give nearest town)  
**Campfield Rd.**  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
**Louisa Barbara Krieg**

3. (b) Social Security Number

4. Sex **F** 5. Color or race **W** 6.(a) Single, married, widowed, or divorced **Widow**  
 6.(b) Name of husband or wife.....**Peter**  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) **July 6 1864**  
 8. AGE: Years **81** Months Days if less than one day  
 .....hrs. ....min.

9. Birthplace.....**Baltimore Md.**  
 (Town, county, and state)  
 10. Usual occupation.....**None**  
 11. Industry or business.....**None**  
 12. Name.....**John Vollner**  
 13. Birthplace.....**Baltimore**  
 14. Maiden name.....**Louisa B. ?**  
 15. Birthplace.....**Baltimore**

16. Informant.....**Records Augsburg Home**  
 Address.....**Campfield Rd.**  
 17. Burial Date thereof.....**3/15/46**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory.....**Mt Carmel**  
 Location.....**Baltimore City**  
 18. Funeral director.....**L. Heemann anddSon**  
 Address.....**32 S. Broadway**  
 19. **3/15** **H. Ruffel**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....**3/12/46** 19..... at **10 a** M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**- May - 12** 19**45** to **March 12** 19**46**  
 and that I last saw her alive on **March 10** 19**46**

Immediate cause of death.....  
**1) Arteriosclerosis**  
**Heart Disease**  
 Due to.....  
 Due to.....**Generalized Arteriosclerosis**  
 Other conditions.....**Phagocytic Infections**  
**Arthritis**  
 (Include pregnancy within 3 months of death)  
 Major findings of operations.....**- None**  
 Date of op.....  
 Autopsy results.....**- None**  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## DURATION

5 yrs.

3 yrs.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?.....  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE.....**Earl L. Chambers** M. D. or other  
**4108 Liberty Hts** Date signed.....**3/13/46**  
 Address.....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Cockeysville P.O. (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Safetone  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Cockeysville P.O. (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

M. Elizabeth Kuntz

## 3. (b) Social Security Number

## 4. Sex

F.

## 5. Color or race

W.

## 6.(a) Single, married, widowed, or divorced

Single

## 6.(b) Name of husband or wife

## 7. Birth date of deceased (mo., day, yr.)

April 18, 1871

## 6.(c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

It less than one day

741021

hrs.

min.

## 9. Birthplace

Balto. Co. Md.  
(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

John Kuntz  
Germany

## 13. Birthplace

## 14. Maiden name

Louise Eckhardt  
Germany

## 15. Birthplace

## 16. Informant

Mrs. George A. Nash  
Cockeysville Md.

## Address

## 17. (Burial, cremation, or removal Which?)

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19.

(Date rec'd by registrar)

19

March 11 46  
Wilmer C. Ensor

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

March 11 1946 at 3:45 A.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 15 1945, to 3/11 1946  
and that I last saw him alive on March 11 1946

## Immediate cause of death

Rickettsia Mollis  
(Coma)

## DURATION

2 yrs

## Due to

## Due to

## Other conditions

Gangrene of foot

(Include pregnancy within 3 months of death)

## Major findings of operations

## Autopsy results

## PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

## 23. SIGNATURE

Wilmer C. Ensor M.D.  
Cockeysville Md.

M. D. or other

Address \_\_\_\_\_ Date signed 3/18/46

RECEIVED  
MAR 13 1946  
BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 57

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Sparks (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 23 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Sparks (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Thomson Mill Rd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Walter Frederick Lawrence

## 3. (b) Social Security Number

4. Sex m. 5. Color or race w. 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Mary Emma (Squire)  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Aug 22, 1864  
 8. AGE: Years 81 Months 6 Days 27 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Ontario Canada  
 (Town, county, and state)  
 10. Usual occupation Exp. Interior Decorator  
 11. Industry or business Self employed  
 12. Name F. J. Lawrence  
 13. Birthplace England  
 14. Maiden name Hannah Lancaster  
 15. Birthplace England

16. Informant Mrs. Geo. E. Muringer  
 Address Sparks, Md.

17. Burial Date thereof Mar. 21, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Sparks Cemetery  
 Location Sparks, Md.

18. Funeral director London M. Brooks  
 Address Sparks, Md.

19. 3/18 46 Wilmer C. Ensor  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 18 19 46 at 3:30 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 19 46 to March 18 19 46  
 and that I last saw him alive on March 17 19 46  
 Immediate cause of death Pneumonia, terminal  
 Due to Myocarditis  
 Due to Incarcerated hernia  
partial  
 Other conditions \_\_\_\_\_

## DURATION

36 hrs.3-14-463-12-46

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Bennett A. Slavin  
Lutherville, Md. M. D. or other  
 Address \_\_\_\_\_ Date signed 3/18/46

RECEIVED  
MAR 20 1946  
BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct-egg is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

02402

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County..... Baltimore

City or town..... Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years Months Days It less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 29 1946 at 3:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 21 1946 to March 29 1946

and that I last saw him alive on March 29 1946

Immediate cause of death

Coronary Thrombosis

DURATION

9 da.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address: Catonsville, Md. Date signed: 3-29-46

RECEIVED

APR 4 1946

BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (41)

## CERTIFICATE OF DEATH

Reg. Dist. No. 02403 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 years 5 months

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 2 years 5 months 29 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1018 South Pace Street  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Julia R. LINGNER

## 3. (b) Social Security Number

4. Sex Female5. Color or race W6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Ambrose LINGNER

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 8<sup>th</sup> 18788. AGE: Years 67 Months 4 Days 5 If less than one day hrs. min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation housewife

11. Industry or business

12. Name Conrad Polster13. Birthplace Maryland14. Maiden name Elizabeth Luttman15. Birthplace Germany16. Informant Hospital records

Address

17. Burial Burial Date thereof 3/16/1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetary or crematory Holy CrossLocation Brooklyn18. Funeral director Howard A. StillAddress 19 W. Penna. ave, Towson19. 3/15 19 46 A. W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 13<sup>th</sup> 1946 at 11:03 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Coronary occlusion

Due to

Diabetic Malacia

Due to

ArteriosclerosisOther conditions sudden death injury

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. M. Kieffer Edna F. Kieffer  
M. D. or otherAddress 1010 Leeds road Date signed 3-13-46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

02404

P

### 1. PLACE OF DEATH:

County.....**Baltimore**  
City or town.....**Catonsville**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? **2 years, 11 mos., 23 days**  
Hospital, institution, or street address where death occurred:  
**Spring Grove State Hospital**  
How long in hospital or institution? **2 years, 11 mos., 23 days**

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State.....**Maryland** County.....**Baltimore**  
City or town.....**701 Mace Avenue**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....**Essex**  
(If rural, give LOCATION)  
2. (a) If veteran, name war.....

### 3. (a) FULL NAME

**Emma C. Lotz**

### 3. (b) Social Security Number

4. Sex.....**female**  
5. Color or race.....**white**  
6. (a) Single, married, widowed, or divorced.....**married**  
6. (b) Name of husband or wife.....**Henry N. Lotz**  
6. (c) If alive, give age.....**72** years  
T. Birth date of deceased (mo., day, yr.).....**April 6, 1866**  
8. AGE: Years.....**79** Months.....**10** Days.....**23**  
If less than one day.....hrs. ....min.

9. Birthplace.....**Maryland**  
(Town, county, and state)  
10. Usual occupation.....**none**  
11. Industry or business.....**none**  
12. Name.....**Henry Jacob Schmincke**  
13. Birthplace.....**Germany**  
14. Maiden name.....**Susan Orte**  
15. Birthplace.....**Germany**

16. Informant.....**Hospital records**  
Address.....**Catonsville-28, Md.**  
17. **Burial** Date thereof.....**March 5, 1946**  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory.....**Landon Park Cemetery**  
Location.....**Fredrick Rd. Balto Tnd**  
18. Funeral director.....**Albert L. Wilk**  
Address.....**1606 N. Chester Street**  
**3-4** **46**  
19. (Date rec'd by registrar) Registrar.....

### MEDICAL CERTIFICATION

2D. DATE OF DEATH.....**March 1** 19..**46** at **12:35 pm**  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**March 6** 19..**43** to **March 1** 19..**46**  
and that I last saw h.....**or alive on March 1** 19..**46**  
Immediate cause of death.....**Acute myocardial insufficiency**  
DURATION.....**minutes**  
Due to.....**Cardiovascular disease,**  
**hypertensive**  
Due to.....**Indef.**  
Other conditions.....**Diabetes mellitus**  
".....

(Include pregnancy within 3 months of death)

Major findings of operations.....Date of op.....  
Autopsy results.....**none**  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
Accident, suicide, or homicide.....Date of.....  
Where did injury occur?.....(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury.....Injured at work?  
**Landon Truck**  
23. SIGNATURE.....**Isadore Tuerk, M.D.** M. D. or other  
Address.....**Catonsville-28, Md.** Date signed.....**3-1-46**

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 0240538

## 1. PLACE OF DEATH:

County BaltimoreCity or town Towson 4, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since February 21, 1946

Hospital, institution, or street address where death occurred:

Eudowood Sanatorium, Towson 4, Md.How long in hospital or institution? Since Feb 21, 1946

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KayserCity or town Belair  
(If outside city or town limits, write RURAL and give nearest town)Street No. Rd # 2  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Joseph Magnus

## 3. (b) Social Security Number

218-14-89434. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married8. (b) Name of husband or wife Georgia Magnus7. Birth date of deceased (mo., day, yr.) April 3, 1918 8. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 27 Months 10 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Belair Md.  
(Town, county, and state)10. Usual occupation Truck Driver

11. Industry or business \_\_\_\_\_

12. Name James R Magnus13. Birthplace Belair Md.14. Maiden name Kristen Umhart15. Birthplace Kingsville Md.

## Personal History-Hospital Records

16. Informant \_\_\_\_\_

Address Eudowood Sanatorium, Towson 4, Md.17. Burial Date there Feb 23, 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Wynona ChapelLocation Harford Co Md.18. Funeral director Chas E CrossAddress Towson 4, Md.19. March 20, 46 19. April 20, 46 Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 20 1946, at 8:52 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 21 1946, to March 20 1946and that I last saw him/her alive on March 19 1946

Immediate cause of death \_\_\_\_\_ DURATION

Pulmonary tuberculosis Since July 1945

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Tuberculosislaryngitis, 2 months

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W A Bridges M. D. or otherAddress Towson 4, Md. Date signed 3-20-46

RECEIVED

APR 2 1946

BUREAU V. 8

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH 02406

## 1. PLACE OF DEATH

County

Village or City

Length of residence in city or town where death occurred

yrs.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

How long in U.S. if of foreign birth?

yrs.

mos.

ds.

## 2. FULL NAME

(a) Residence: No.

(Usual place of abode)

St.

Ward.

Registration Dist. No.

41

Ward

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year)

7. AGE

Years

Months

Days

If LESS than

1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country)

FATHER

13. NAME

14. BIRTHPLACE (city or town) (State or country)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT

(Address)

18. BURIAL, CREMATION, OR REMOVAL

Place

Date

19. UNDERTAKER

(Address)

20. FILED

3/4/46

Registrar

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

(Month)

(Day)

(Year)

22. I HEREBY CERTIFY, That I attended deceased from

Mar 1, 1946 to Mar 1, 1946

I last saw him alive on Mar 1, 1946; death is said

to have occurred on the date stated above, at 6:30 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Date of onset

Carbon monoxide poisoning.

Other Contributory Causes of importance:

Suffocation.

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Suicide Date of injury 3/1/46

Where did injury occur? at home (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

M. D.

(Address)

If more blanks are needed, address State Registrar, 241 N. Charles Street, Baltimore, Requesting U. S. No. 1.



# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

## Example I

The principal cause of death and related causes of importance were as follows:

*Arteriosclerosis*

*1915*

*Chronic interstitial nephritis*

*1921*

*Cerebral hemorrhage*

*July 5, 1927*

Other contributory causes of importance:

*Gallstones*

*May 1, 1923*

## Example II

The principal cause of death and related causes of importance were as follows:

*Attack of epilepsy*

*1 week ago*

*Run over by street car*

*1 week ago*

*Peritonitis*

*3 days ago*

Other contributory causes of importance:

*Gastroenteritis*

*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CHANGE OF AGE:  
Letter filmed 4-9-46 G101  
from Dr. F.V. Beitler.-L

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (520)

## CERTIFICATE OF DEATH

02407

Reg. Dist. No. 42

1. PLACE OF DEATH: Baltimore  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 year  
Hospital, institution, or street address where death occurred:  
5200 Carroll Place  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5200 Carroll Place  
(If rural, give LOCATION)  
2. (a) If veteran, name war None

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed  
6. (b) Name of husband or wife Shadens Marcyak

7. Birth date of deceased (mo., day, yr.) June 21, 1883 6. (c) If alive, give age 63 years

8. AGE: Years 63 Months 9 Days 1926 If less than one day  
.....hrs. ....min.

9. Birthplace Poland  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Adamczyk

13. Birthplace Poland

14. Maiden name Sieroni

15. Birthplace Poland

16. Informant Mrs. Estelle Stasiowski

Address 5200 Carroll Pl. Baltimore

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Apr 2, 1946  
(month) (day) (year)

Cemetery or crematory St. Stanislaus Lem

Location Chicopee Mass.

18. Funeral director Easton

Address 608 Frederick Ave Catonsville, Md.

19. Mar 30 46 Dr. Keffler  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 29 1946 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 to March 1946

and that I last saw him/her alive on Feb 28 1946

Immediate cause of death Undulant Fever

Due to Tumor of Lungs

Due to Probably hypopharyngeal

Other conditions Dehydration Duration unknown

(Include pregnancy within 3 months of death)

Major findings of operations ✓

Date of op. ✓

Autopsy results ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frederick V. Beitler

Address 1014 Drums Ave N. York 27 Date signed 3-30-46

M. D. or other

RECEIVED  
APR 2 1946  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

02408

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Mount Wilson, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 yrs., 8 mos., 18 days  
 Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium  
 How long in hospital or institution? 5 yrs., 8 mos., 18 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Upperco  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Doris Martin

## 3. (b) Social Security Number

None

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>	
6. (b) Name of husband or wife _____			
6. (c) If alive, give age _____ years			
7. Birth date of deceased (mo., day, yr.) <u>January 5, 1924</u>			
8. AGE: Years <u>22</u>	Months <u>2</u>	Days <u>24</u>	If less than one day _____ hrs. _____ min.

9. Birthplace Upperco, Maryland  
(Town, county, and state)10. Usual occupation None

11. Industry or business \_\_\_\_\_

12. Name J. Herbert Martin13. Birthplace Upperco, Maryland14. Maiden name Lola Belt15. Birthplace Upperco, Maryland16. Informant Doris MartinAddress Upperco, Maryland17. Burial Date thereof April 1, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Paul's CemeteryLocation Arcadia, Maryland18. Funeral director Edward C. TiptonAddress Hampstead, Maryland19. March 29, 1946  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1946 at 7:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 11, 1940 to March 29, 1946  
 and that I last saw her alive on March 29, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 6 Yrs.

Due to Tubercle Bacilli

Due to \_\_\_\_\_

Other conditions Bronchiectasis 4 Yrs.  
Myocarditis Unknown  
 (Include pregnancy within 3 months of death)

Major findings of operations No operation  
 Date of op. \_\_\_\_\_

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Stewart S. Shaffer M.D. M.D. or otherAddress Mount Wilson, Md. Date signed 3/29/46Rec'd - 3-30-46 - Dr. E. E. Tipton

RECEIVED

APR 1 1946

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 024038

## 1. PLACE OF DEATH:

County BaltimoreCity or town West Hills  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Martin Dr. + Charing Cross Rd.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town West Hills  
(If outside city or town limits, write RURAL and give nearest town)Street No. Martin Dr. + Charing Cross  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Thomas Patrick Martin

## 3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

None

7. Birth date of

deceased (mo., day, yr.)

Nov. 11, 1874

8. AGE:

Years

Months

Days

If less than one day

71320hrs.min.

9. Birthplace

Franklinton, Balto. Co. Md.  
(Town, county, and state)

10. Usual occupation

Contractor + Quarryman

11. Industry or business

FATHER

12. Name

Thomas R. Martin

13. Birthplace

Co. Weyford, Ireland

MOTHER

14. Maiden name

Mary + self

15. Birthplace

Washington, D. C.

16. Informant

Edward F. Martin

Address

Martin Dr. + Charing Cross

17.

(Burial, cremation, or removal. Which?)

Date thereof

Mar. 6, 1946  
(month) (day) (year)

Cemetery or crematory

New Cathedral

Location

4300 Old Fred. Rd. Balto. Md.

18. Funeral director

Eastern Cross

Address

608 Frederick Ave. Catonsville

19.

(Date rec'd by registrar)

3-51946Harrold Miller  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 3, 1946, at 10:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 2, 1946, to Mar. 3, 1946and that I last saw h. alive on Mar. 3, 1946

Immediate cause of death

Coronary Thrombosis

DURATION

2 mons.

Due to

Arterio Sclerotic Cardio

Due to

Vascular Disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James H. Houbert  
M. D. or other

Address

CatonsvilleDate signed 3-4



RECEIVED  
APR 6 1946  
BUREAU V. R.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23a)

## CERTIFICATE OF DEATH

02410

Reg. Dist. No. 40

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Baldwin  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Paper Mill Road & Manor Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. As in No 1  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary B Mast

## 3. (b) Social Security Number

----

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Lee H Mast

6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) May 9 1899

8. AGE: Years 46 Months 10 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Kent County, Md  
 (Town, county, and state)

10. Usual occupation At Home

11. Industry or business

12. Name Raymond Bowers13. Birthplace Kent County, Md14. Maiden name Smith15. Birthplace Kent County, Md.16. Informant Mr. Lee H MastAddress Paper Mill Rd Baldwin P. O. Md

17. Burial Date thereof 3/27/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetary or crematory Trinity EpiscopalLocation Long Green18. Funeral director Lassahn Funeral HomeAddress 7401 Belair Road

3/28/46 W. M. Naumett  
 (Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

3/24/46 5:15 AM

20. DATE OF DEATH 19\_\_\_\_ at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 24, 1946  
 and that I last saw him alive on March 24, 1946

Immediate cause of death Convulsions DURATION 4 hours

Due to Cerebral Hemorrhage 2 days

Other conditions Caesarean by partner 2 yrs  
 (Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results \_\_\_\_\_ Date of op. \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Walter M. Hammett M. D. or other \_\_\_\_\_  
Baldwin 3/28/46  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

STATE OF NEW YORK

DEPARTMENT OF HEALTH

RECEIVED

APR 3 1946

BUREAU V S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02411

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

### 1. PLACE OF DEATH:

County BALTIMORE  
City or town TOWSON  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 YEARS, 5 MOS., 9 DAS.  
Hospital, institution, or street address where death occurred:  
THE SHEPPARD AND ENOCH PRATT HOSPITAL  
How long in hospital or institution? 4 YEARS, 5 MOS., 9 DAS.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County \_\_\_\_\_  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5 W. 29th Street  
(If rural, give LOCATION)  
2(a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

CATHERINE BRIDGET MCCAUGHAN

### 3. (b) Social Security Number

(MCCAUGHAN) (MCCAUGHAN)

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of Definite date: \_\_\_\_\_ 8. (c) If alive, give age \_\_\_\_\_ years  
deceased (mo., day, yr.) Unknown - 1864?

8. AGE: Years 82 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
Approximate

9. Birthplace Allegheny County, Md.  
(Town, county, and state)

10. Usual occupation teacher

11. Industry or business \_\_\_\_\_

FATHER 12. Name John McCaughan

13. Birthplace Ireland

MOTHER 14. Maiden name Unknown

15. Birthplace Ireland

16. Informant HOSPITAL RECORDS

Address \_\_\_\_\_

17. Burial Date thereof 3/29/46  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory St. Michael's Cem.

Location Allegheny Co. Md.

18. Funeral director C. Vernon Lemmon

Address 4611 Park Heights, Balto.

3/28/46 (Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 26 19 46 at 6:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 17 19 41 to March 26 19 46

and that I last saw her alive on March 26 19 46

Immediate cause of death Chronic sclerosis of the coronary vessels DURATION Terminal

Due to generalized arteriosclerosis Unk

Other conditions Chronic myocarditis Unk  
Senile dementia Syr +  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results Confirms above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. W. ELGIN, M.D. M. D. or other \_\_\_\_\_

Address TOWSON, MD. Date signed 3/27/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02412

Reg. Dist. No. 33-

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Rural near Freeland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 25 yrs.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Rural near Freeland  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. near Eklo  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

Charles M. McGraw

## 3. (b) Social Security Number

219-05-5765

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Blanche B. McGraw  
 6. (c) If alive, give age 54 years  
 7. Birth date of deceased (mo., day, yr.) October 16, 1889  
 8. AGE: Years 56 Months 4 Days 24 If less than one day  
 hrs. min.

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Mar. 10 1946 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19   to 19    
 and that I last saw h. alive on 19  

Immediate cause of death

Shotgun wound of head

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of Mar. 10, 1946Where did injury occur? Freeland, Md.  
 (City or town) (County) (State)Injured at home, farm, industry, public place (where?) at home

Means of injury

Injured at work?

23. SIGNATURE

A. M. France

M. D. or other

Address Parkton, Ind. Date signed 3/13/46

9. Birthplace Virginia  
 (Town, county, and state)  
 10. Usual occupation Construction work  
 11. Industry or business  
 12. Name R. H. McGraw  
 13. Birthplace Virginia  
 14. Maiden name Catherine Gillespie  
 15. Birthplace Virginia  
 16. Informant Mr. John McGraw  
 Address Freeland Md. R.D.  
 17. Burial Date thereof March 13, 1946  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Middleton  
 Location Freeland Md. R.D.  
 18. Funeral director Joseph Harrison  
 Address New Freedom Pa.  
 19. Mar '10 1946 Charles S. Ellison  
 (Date rec'd by registrar) (City or town) Registrar

RECEIVED  
MAR 26 1946  
BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore <sup>92d</sup>

## CERTIFICATE OF DEATH

02413

Reg. Dist. No. 35

## 1. PLACE OF DEATH:

County BaltimoreCity or town Parkton  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 73 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Parkton  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Sarah Jane Measley

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife

Jacob Measley

7. Birth date of deceased (mo., day, yr.)

November 25, 1865

6.(c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

80312

hrs.

min.

9. Birthplace

York Co., Penna.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Own home

12. Name

Unknown

13. Birthplace

"

14. Maiden name

Unknown

15. Birthplace

16. Informant

Address

Burial  
(Burial, cremation, or removal. Which?)Date thereof March 9, 1946  
(month) (day) (year)

Cemetery or crematory

New Freedom Cemetery

Location

New Freedom Pa.

18. Funeral director

Address

Mar 8, 1946  
(Date rec'd by registrar)Charles E. Fisher  
Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1946, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 19, 46 to March 7, 46  
and that I last saw him alive on Feb 16, 46Immediate cause of death Chronic Valvular  
Heart Disease  
Broken Compensation

DURATION

10 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

Walter Bortner M.D.  
M. D. or otherAddress White Hall Date signed March 7, 46

RECEIVED

MAR 27 1946

BUREAU V.R.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02414

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Laurel Hill LaneHow long in hospital or institution? In U. S. 55 yrs.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. Laurel Hill Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Bertha M. Menzel

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Widow

## 6.(b) Name of husband or wife

Late Oscar Menzel

6.(c) If alive, give age..... years

## 7. Birth date of

deceased (mo., day, yr.)

March 19, 1872.

## 8. AGE:

Years

Months

Days

If less than one day

7412

hrs.

min.

## 9. Birthplace

Germany

(Town, county, and state)

## 10. Usual occupation

H. W.

## 11. Industry or business

FATHER

## 12. Name

George Eichebeck

## 13. Birthplace

Germany

MOTHER

## 14. Maiden name

Unknown

## 15. Birthplace

Germany

## 16. Informant

Mr. Herman G. Menzel

Address

Laurel Hill Lane

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof April 3/46.  
(month) (day) (year)

## Cemetery or crematory

Loudon Park

## Location

3801 Frederick Road

## 18. Funeral director

Address

4101 Edmondson Ave.19. 4-3  
(Date rec'd by registrar)19. 46Harvey H. Miller  
deputy

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 31/46. 19....., at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb-2- 19 46 to March-31- 19 46.and that I last saw him/her alive on March-31- 19 46.

Immediate cause of death

Edema of Lungs

DURATION

1 day

Due to

Chronic myocarditis2 yrs

Due to

Aortic Regurgitation3 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E. Gill Hall M.D.  
M. D. or otherAddress 1631 E. North Ave. Date signed 4/2/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED THE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

REPORTED BY

DATE OF REPORT

RECEIVED

APR 5 1946

BUREAU OF

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

02415

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 5501 Edmondson Ave.

(c) Hospital or institution:

Hood Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 10 yrs.

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Baltimore

(If outside city or town limits, write RURAL and give town)

(d) Street No. 624 Plymouth Rd.

(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

## 3 (a) FULL NAME

Ruth Y. Mercier

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Eston O. Mercier

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1898

8. AGE: Years Months Days If less than one day

9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

12. Name John Carr

13. Birthplace Baltimore, Md.

14. Maiden Name Jennie Pope

15. Birthplace Baltimore, Md.

16 (a) Informant Mr. Eston O. Mercier

(b) Address 624 Plymouth Rd.

17 (a) Burial (b) Date thereof 3/25/46

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory Woodlawn

Location Baltimore County

18 (a) Funeral director Frederick A. Cole

(b) Address 1200 N. Lombard St.

19 (a) Date of registration 3/25/46

(b) Signature by registrar Huntington Williams, M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 21, 1946, at 4:40 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 10/9/39 to 3/21/46, and that I last saw her alive on 3/19/46.

Immediate cause of death

General Carcinoma of Breast

Due to

Other Conditions

Duration

6 months

18 months

## PHYSICIAN

Underline the cause to which death should be charged statistically.

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Elisha W. Johnson

Address 3432 Frederick Ave. Date signed 3/27/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02426

Reg. Dist. No. 31

## 1. PLACE OF DEATH:

County.....Baltimore

City or town.....Larchmont  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

2304 Poplar Drive

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Baltimore

City or town.....Larchmont  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....2304 Poplar Drive

(If rural, give LOCATION)

World War # 1

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

J. NEWTON MERRITT

## 3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife.....Georgie Beaumont Merritt

B.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.).....April 14, 1893

8. AGE:	Years	Months	Days	If less than one day
	52	11	8	.....hrs. ....min.

9. Birthplace.....Baltimore  
(Town, county, and state)

10. Usual occupation.....Sales Manager

11. Industry or business.....Corkran-Hill Co.

12. Name.....Alonzo I. Merritt

13. Birthplace.....A. A. Co., Md.

14. Maiden name.....Sophia A. Heyn

15. Birthplace.....Baltimore, Maryland

16. Informant.....Mrs. J. Newton Merritt

Address.....2304 Poplar Drive, Larchmont

17. Burial Date thereof.....3/25/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....Woodlawn Cemetery

Location.....Woodlawn, Maryland

18. Funeral director.....WM. J. TICKNER &amp; SONS

Address.....Baltimore, Maryland

19. 3-25-46 A. W. Thdrach Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....March 22, 19 46, at 10:45A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 29, 19 45, to March 22, 19 46

and that I last saw h.....in alive on March 21, 19 46

Immediate cause of death.....Coronary Thrombosis

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....3030 Edmondson Ave. Date signed.....3/23/46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1246

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County Baltimore  
City or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 Days  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp., Fort Howard, Maryland  
How long in hospital or institution? 3 Days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AA  
City or town Point Pleasant  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. R.F.D. Box, 241  
(If rural, give LOCATION)  
2.(a) If veteran, name war ✓

### 3. (a) FULL NAME

ARNOLD ROBERT MERSON

### 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Mable Merson

6. (c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) 8-5-10

8. AGE: Years Months Days If less than one day  
35 7 18 ..... hrs. .... min.

9. Birthplace Glen Burnie, Md.  
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

12. Name Edward Merson  
13. Birthplace Baltimore, Md.

14. Maiden name ? Engelmann  
15. Birthplace Europe

16. Informant Clinical Records, Vets. Adm. Hosp.  
Address Fort Howard, Md.

17. Burial Date thereof March 26 / 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Baltimore National Cemetery  
Baltimore, Md.  
Location

18. Funeral director A. Lee Oder  
Address 4644 York Road., Balto., Md.

19. 3-25- 46 D. W. Hedrich  
(Date rec'd by registrar) (Year) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 23, 1946 at 9:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20, 1946 to March 23, 1946  
and that I last saw him alive on March 23, 1946

Immediate cause of death Hemorrhage DURATION 3 Days

Due to Rupture of esophageal varices 3 Days

Due to Cirrhosis of liver Unknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. M. Balter M. D. or other  
A. M. BALTER, LT. COL., M.C. CLIN. DIR.  
Address Fort Howard, Md. Date signed 3-25-46

MARGIN RESERVED FOR BINDING

VS A15 94575M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

02417

P

44



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

02418 38  
Reg. Dist. No.

## 1. PLACE OF DEATH

County Baltimore County (Dis #7)  
City or town Shane, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State 4th Dist. County Balto. Co.City or town Shane  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2nd, Old York Rd.  
(If rural, give LOCATION)2. (a) If veteran, name war 1st

## 3. (a) FULL NAME

Eugenia C. Miller

## 3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Lynn T. Miller

7. Birth date of deceased (mo., day, yr.)

Feb. 13, 1853

6. (c) If alive, give age..... years

8. AGE:

Years 93Months 1Days 6

If less than one day

..... hrs. .... min.

9. Birthplace

Baltimore, Md.  
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Robert T. Travers

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Funeral

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

19. 40

Registral

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 19, 1946 at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. 40 to Mar. 19, 1946and that I last saw her alive on Mar. 18, 1946

Immediate cause of death

Chronic myocarditis

DURATION

Due to

Due to

Other conditions

Anterior sclerous

(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. W. FranceAddress Parkton, Md. Date signed 3/19/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 920

## CERTIFICATE OF DEATH

Reg. Dist. No. 02419 42

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Halethorpe 27. Md  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Natal, institution, or street address where death occurred  
3509. Washington Blvd.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Halethorpe 27. Md  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 3509. Washington Blvd.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Lucy Miller

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

John Miller

7. Birth date of deceased (mo., day, yr.)

Sept 15 - 1863

6. (c) If alive, give age years

8. AGE: 82 Years 6 Months 7 Days If less than one day

9. Birthplace

BALTO. CO. MD.  
 (Town, county, and state)

10. Usual occupation

NONE

11. Industry or business

12. Name

NOT KNOWN

13. Birthplace

NOT KNOWN

14. Maiden name

NOT KNOWN

15. Birthplace

NOT KNOWN

16. Informant

MR GEO E LOTTERER

Address 3509 WASHINGTON BLVD.

17. BURIAL Date thereof MARCH 15-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory CATHEDRAL CEM.

Location BALTO MD

18. Funeral director Bernard G Harbo

Address 121 E West St

19. 31.3 19 46 Q. H. H. H.

(Date rec'd by Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1946 at 8:45 PM

21. I CERTIFY that death occurred on the date above stated; That I attended deceased from

Feb. 8 - 1946 19 46 March 12 19 46

and that I last saw him alive on March 11 1946 19 46

Immediate cause of death

Cerebral Hemorrhage

Due to

Arterial Hypertension

Chronic myocarditis

Due to

Active Stenosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. E. Fitzgerald

Address Chesham, Md M. D. or other

Date signed 3/12/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

## CERTIFICATE OF DEATH

 02420  
 ★ Reg. Dist. No. 38-

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Rural near Freeland.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 wks.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Rural near Freeland.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. North of Freeland.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary Ellen Miller

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Widow.

## 6.(b) Name of husband or wife

Reuben Miller

## 7. Birth date of

deceased (mo., day, yr.)

July 22, 1869.

## 8.(c) If alive, give age

## 8. AGE:

Years

Months

Days

If less than one day

7679

hrs.

min.

## 9. Birthplace

Jerome, Va.

(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

Own home.

## FATHER

## 12. Name

Israel Funkhouser.

## 13. Birthplace

Virginia.

## MOTHER

## 14. Maiden name

Unknown

## 15. Birthplace

## 16. Informant

Mrs. Vertie Bowman

## Address

Freeland, Md. R.D.

## 17. Removal

(Burial, cremation, or removal. Which?)

## Date thereof

March 2, 1946

(month) (day) (year)

## Cemetery or crematory

Mt. Zion Lutheran

## Location

Edinburg, Va.

## 18. Funeral director

J. Jacob Hartenstein

## Address

New Freedom, Va.

## 19.

Mar 219 46Chas. E. Linder

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

March 1,19 46at 4:35 P. M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 1519 46to Mar. 119 46

## and that I last saw him

alive onFeb. 2719 46

## Immediate cause of death

Cerebral thrombosis

## DURATION

2 weeks

## Due to

## Due to

## Other conditions

arterio-scleroticarterio-sclerotic

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

## Accident, suicide, or homicide

Date of

## Where did injury occur?

(City or town)

(County)

(State)

## Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

G. W. Frame

M. D. or other

## Address

Parkton, Md.Date signed 2/2/46

RECEIVED

MAR 27 1946

BUREAU V.B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02421

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

### 1. PLACE OF DEATH

County Baltimore  
City or town Turner Station (Day Village)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 yrs.  
Hospital, institution, or street address where death occurred:  
805 Avondale Road  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Turners Station (Day Village)  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 805 Avondale Road.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Mrs. Helen Andrews Mosby

### 3. (b) Social Security Number

None

4. Sex F 5. Color or race Negro 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife John Alexander Mosby  
6.(c) If alive, give age 50 years  
7. Birth date of deceased (mo., day, yr.) July 23, 1907  
8. AGE: Years 38 Months 7 Days 10 If less than one day — hrs. — min.

9. Birthplace Charlottesville, Mecklenburg County, N.C.  
(Town, county, and state)

10. Usual occupation Housewife

### 11. Industry or business

12. Name Samuel Andrews  
13. Birthplace North Carolina  
14. Maiden name Sabra Johnson  
15. Birthplace South Carolina

16. Informant Mrs. Mildred Andrews Williams  
Address 716 Avondale Rd.

17. Burial Burial Date thereof Mar-6-46  
(Burial, cremation, or removal, which?) (month) (day) (year)  
Cemetery or crematory Arbutus Mem. Park  
Location Baltimore Co., Md.

18. Funeral director Mrs. Frances A. Hensley  
Address 578 W. Biddle St.

19. 3/3 19 46 John S. Connelley  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 2, 1946, at 6:18 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 1946, to March 2, 1946  
and that I last saw him or alive on March 2, 1946

Immediate cause of death Right Lobar Pneumonia

### DURATION

4 days

Due to —

Due to —

Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE William S. Madsen M.D.  
M. D. or other —

Address 140 Oak Ave Date signed 3-2-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 8 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

## CERTIFICATE OF DEATH

02422

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County... Baltimore  
 City or town... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 months, 18 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 5 months, 18 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Prince George's  
 City or town... Brantwood Avenue  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... 4007 Utah Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

Edward D. Muller

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife... Constance (maiden name) ...  
Day 8. (c) If alive, give age 54 years  
 7. Birth date of deceased (mo., day, yr.) February 8th, 1886  
 8. AGE: Years 60 Months 1 Days 22 If less than one day  
 ... hrs. ... min.

## MEDICAL CERTIFICATION

20. DATE OF DEATH... March 30, 1946 19... at... M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
October 12, 19 45, to March 30 19 46  
 and that I last saw him alive on March 30th 19 46  
 Immediate cause of death Terminal broncho-  
pneumonia DURATION  
18 hrs

Due to... General Paresis  
(Syphilis)

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. ...

Autopsy results... None held

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Henry C. A. Mead, M.D. M.D. or otherAddress... Catonsville, 28, Md. Date signed 3/30/46

9. Birthplace... Washington, D. C.  
 (Town, county, and state)  
 10. Usual occupation... Baker  
 11. Industry or business Food production  
 12. Name... John F. Muller  
 13. Birthplace Germany  
 14. Maiden name... Dora (Unknown)  
 15. Birthplace Germany

16. Informant... Hospital Records, Spring Grove State  
 Address Hospital, Catonsville, 28, Md.

17. Removal Date thereof Mar 30 - 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory...

Location...

18. Funeral director... Wm. J. GalleyAddress 3200 St. I. Ave. S.W. Rainier Bldg

19. 3-31 19 46 Harry D. Muller  
 (Date rec'd by registrar) (month) (day) (year) deputy Registrar

RECEIVED  
APR 1 1946  
BUREAU OF



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02423

Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Mount Wilson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 yrs., 7 mos., 18 days  
 Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium  
 How long in hospital or institution? 7 yrs., 7 mos., 18 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town 2910 Rosalie Avenue, Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2910 Rosalie Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Joseph A. Nemec

## 3.(b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife \_\_\_\_\_ 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) January 20, 1919  
 8. AGE: Years 27 Months 1 Days 15 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation Clerk

## 11. Industry or business

12. Name Joseph Nemec  
 13. Birthplace Maryland  
 14. Maiden name Goldie Danmyer  
 15. Birthplace Maryland

16. Informant Joseph Nemec  
 Address 2910 Rosalie Ave., Balto., Md.

17. Burial Burial Date thereof March 11, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Holy Redeemer Cemetery  
 Location 4430 Belair Rd., Balto., Md.

18. Funeral director F. Cvach & Son  
 Address 900 N. Chester St., Balto., Md.

19. March 7, 1946 Earl T. Webster  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 7, 1946 at 2:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17, 1938 to March 7, 1946  
 and that I last saw him alive on March 7, 1946

Immediate cause of death Pulmonary Tuberculosis DURATION 17  
Years

Due to Tubercle Bacilli

Due to \_\_\_\_\_

Other conditions Myocarditis Unknown

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Autopsy results No autopsy Date of op. \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Stewart S. Shaffer M.D. M. D. or other \_\_\_\_\_

Address Mount Wilson, Md. Date signed 3/7/46

Rec'd 3 - 9 - 46 - Mr. E. E. Nichols

RECEIVED

MAR 11 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

## CERTIFICATE OF DEATH

Reg. Dist. No. 12424 44

## 1. PLACE OF DEATH:

County BaltoCity or town Edgewater Apartments

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

38 Seaford Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltoCity or town Edgewater Apt

(If outside city or town limits, write RURAL and give nearest town)

Street No. 38 Seaford Ave.

(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Laura Virginia Nichols

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (c) Single, married, widowed, or divorced widow6. (b) Name of husband or wife Samuel Nichols

7. Birth date of

deceased (mo., day, yr.)

march 17 - 1877

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

69

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

at home

11. Industry or business

FATHER

12. Name

John Hause

13. Birthplace

md

MOTHER

14. Maiden name

Unknown

15. Birthplace

16. Informant

Helen Ellzich

Address

38 Seaford Ave

17.

(Burial, cremation, or removal. Which?)

Date thereof

4/2/46

Cemetery or crematory

St. Marys

Location

Dampden

18. Funeral director

John J. Connelly

Address

418 Eastern Ave. Essex 21

19.

(Date rec'd by registrar)

19

Date

19

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH march 31 19 46 at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

march 23 19 46 to march 31 19 46and that I last saw her alive on march 31 19 46

Immediate cause of death

Cerebral apoplexy

DURATION

1 day

Due to

arterio-sclerotic

Due to

cardio-vascular disease

Other conditions

(include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. W. W. W. W. W.

M. D. or other

Address

Balto 6

Date signed

7/2/46

RECEIVED

APR 4 1946

BUREAU V.S.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH 02425

## 1. PLACE OF DEATH

County

Village or City

No.

Registration Dist. No.

41

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S. if of foreign birth?

yrs.

mos.

ds.

## 2. FULL NAME

(a) Residence: No.

(Usual place of abode)

St.

Ward.

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED,  
OR DIVORCED (write the word)

male

white

5a. If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

6. DATE OF BIRTH (month, day, and year)

7. AGE

Years

Months

Days

If LESS than  
1 day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.

OCCUPATION

8. Trade, profession, or particular  
kind of work done, as SPINNER,  
SAWYER, BOOKKEEPER, etc.9. Industry or business in which  
work was done, as SILK MILL,  
SAW MILL, BANK, etc.10. Data deceased last worked at  
this occupation (month and  
year)11. Total time (years)  
spent in this  
occupation12. BIRTHPLACE (city or town)  
(State or country)

FATHER

13. NAME

14. BIRTHPLACE (city or town)  
(State or country)

MOTHER

15. MAIDEN NAME

16. BIRTHPLACE (city or town)  
(State or country)17. INFORMANT  
(Address)

18. BURIAL, CREMATION, OR REMOVAL

Place

Date

19. UNDERTAKER  
(Address)

20. FILED

19

46

If more blanks are needed, address State Registrar, 2421 N. Charles Street, Baltimore, Requesting Form No. 1.

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

(Month)

(Day)

(Year)

22.

I HEREBY CERTIFY, That I attended deceased from

I last saw him

alive on

to

19

;

death is said

to have occurred on the date stated above, at 4 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance  
were as follows:

Data of onset

Other Contributory Causes of importance:

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury

19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed)

(Address)

M. D.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462

02426

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

## 1. PLACE OF DEATH:

County BaltimoreCity or town Owings Mills  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County BaltimoreCity or town Owings Mills  
(If outside city or town limits, write RURAL and give nearest town)Street No. Balfield Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Martha Ann Powell

## 3. (b) Social Security Number

none4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow8. (b) Name of husband or wife James W. Powell7. Birth date of deceased (mo., day, yr.) March 15 1859 5. (c) If alive, give age..... years8. AGE: 86 Years 11 Months 18 Days If less than one day..... hrs. .... min.9. Birthplace Howard Co Md  
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Amos Duwall

13. Birthplace

14. Maiden name Martha Shelby15. Birthplace John C. Powell16. Informant BurialAddress Balfield Rd - Owings Mills17. (Burial, cremation, or removal. Which?) Burial Date thereof March 18 1946  
(month) (day) (year)Cemetery or crematory Randon ParkLocation Bates Md18. Funeral director Robt C & B. M. WaltersAddress Pratt, Stricker, Ste. Bates Md19. 3/15/46 1946 R. E. Martin  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1946, at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1945 to Mar. 15 1946  
and that I last saw him alive on Mar. 13 1946

Immediate cause of death

Carcinoma of Colon

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. E. Martin M. D. or other  
Address Randallstown Date signed 3/15/46

RECEIVED  
MAR 26 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02427

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

## 1. PLACE OF DEATH:

County Balto. Co.City or town 201 Balnaw Ave

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years.Hospital, institution, or street address where death occurred: How long in hospital or institution? 

## 3. (a) FULL NAME

Robert E. Powell

## 3. (b) Social Security Number

4. Sex M5. Color or race col6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife 6. (c) If alive, give age  years7. Birth date of deceased (mo., day, yr.) Sept. 18, 18908. AGE: Years 55 Months 5 Days 12 If less than one day  hrs.  min.9. Birthplace Blackridge, Va.  
(Town, county, and state)10. Usual occupation Labour11. Industry or business Bethlehem Steel Co12. Name Anthony Powell13. Birthplace Va14. Maiden name Frances ?15. Birthplace Va.16. Informant Martin PowellAddress 201 Balnaw Ave17. Removal - Shipped 3-3-46

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Blackridge Va.Location MECKLENBURG Co. Va.18. Funeral director WILLIAM A. JACKSONAddress 916 PENNA. AVE, BALTO.19. 3/1 46

(Date rec'd by registrar)

Meen M. Mendenhall  
Local Deputy Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltoCity or town Dundalk 22nd

(If outside city or town limits, write RURAL and give nearest town)

Street No. 201 Balnaw Ave

(If rural, give LOCATION)

2. (a) If veteran, name war 

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1st 46 at 5:30 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 2 1945 to March 1st 1946and that I last saw him alive on March 1st 1946Immediate cause of death Cerebral apoplexy

DURATION

4 daysDue to Due to arterio sclerosis unknownOther conditions 

(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results 

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of Where did injury occur?  (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury  Injured at work? 23. SIGNATURE J. N. Thomas M.D.Address Dundalk 22nd Date signed 3/1/46M. Mendenhall, Reg.

CERTIFICATE OF DEATH

RECEIVED  
MAR 4 1946  
BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 88-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 0242830

## 1. PLACE OF DEATH:

County..... Baltimore

City or town..... Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Sixteen days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution?..... Sixteen days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore

City or town..... Baltimore Highlands  
(If outside city or town limits, write RURAL and give nearest town)Street No..... 2915 Delaware Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Lillian Powers

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife..... Andrew Powers

6. (c) If alive, give age..... 42 years

7. Birth date of deceased (mo., day, yr.)..... May 7 1903

8. AGE: Years Months Days If less than one day  
42 10 9 ..... hrs. .... min.9. Birthplace..... Maryland  
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... None

FATHER 12. Name..... Edward Reisler

13. Birthplace..... Germany

MOTHER 14. Maiden name..... Dora Bocher

15. Birthplace..... Germany

16. Informant..... Hospital records, Spring Grove Hosp.

Address..... Catonsville, 28, Md.

17. Burial (Burial, cremation, or removal, which?)..... 3. 19. 46  
Date thereof (month) (day) (year)

Cemetery or crematory..... Western

Location..... Edmondson Ave + Longwood St

18. Funeral director..... Harry H. W. White

Address..... 44101 Edmondson Ave.

19. 3-19-46  
(Date rec'd by registrar) Harry H. White Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 16 1946 ..... 19..... at 3:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 1st, 1946 ..... 19..... to March 16, 1946  
and that I last saw h..... er alive on March 16, 1946 ..... 19.....Immediate cause of death..... Cerebral Thrombosis  
DURATION 3 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE..... HENRY C. A. MEAD, M. D. M. D. or other

Address..... Catonsville, 28, Md. Date signed 3/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 20 1946  
BUREAU V.A.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 922

## CERTIFICATE OF DEATH

Reg. Dist. No. 024288

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp., Fort Howard, Maryland  
 How long in hospital or institution? 12 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset  
 City or town Chance  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. (Box 17)  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war W.W.I.

## 3. (a) FULL NAME

ERNEST J. PRICE

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single  
 6. (b) Name of husband or wife none  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) March 30, 1896  
 8. AGE: Years 49 Months 11 Days 27 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Chance, Maryland  
 (Town, county, and state)  
 10. Usual occupation Clerk  
 11. Industry or business unknown  
 FATHER 12. Name John Price  
 13. Birthplace Maryland  
 MOTHER 14. Maiden name Eva Charlotte Webster  
 15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.  
 Address Ft. Howard, Maryland  
 17. Burial Date thereof 3-28-46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Chance Cem.  
 Location Chance, Md.  
 18. Funeral director Leonard J. Kuck  
 Address 5305 N. H. Rd.  
 19. 3/28 46 A. M. Bacon  
 (Date rec'd by registrar) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 27 1946 at 1:40 p.m.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 16 46 to March 27 19 46  
 and that I last saw him im alive on March 27 19 46  
 Immediate cause of death \_\_\_\_\_ DURATION  
HEART DISEASE RHEUMATISM, MITRAL  
INSUFFICIENCY, AORTIC STENOSIS,  
CARDIAC ENLARGEMENT, MYOCARDIAL  
INSUFFICIENCY, AURICULAR  
FIBRILLATION 1 year  
plus  
 Other conditions PULMONARY EMBOLISM WITH  
INFARCTION 2 days  
BRONCHOPNEUMONIA (declare pregnancy within 3 months of death) 11 days  
 Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_ Date of op. \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE am Balter  
A. M. BALTER, LT. COL., M.D. CLIN. DIR.  
 Address Fort Howard, Md. Date signed 3-27-46

RECEIVED  
MAR 30 1946  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Baltimore  
 City or town md (Arbutus)  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltimoreCity or town Arbutus  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1263 Linden Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

William Frederick Raabe

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W.

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Mary Ella6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.)

Jan 15, 1879

8. AGE:

Years

Months

Days

If less than one day

67114

hrs.

min.

9. Birthplace

Baltimore, md  
(Town, county, and state)

10. Usual occupation

Maintenance Man

11. Industry or business

md State Road Corp

FATHER

12. Name

Frederick W. Raabe

13. Birthplace

Kiel, Germany

MOTHER

14. Maiden name

Louise Gottschalk

15. Birthplace

Muenchenburg, Germany

16. Informant

Mrs Mary E. Raabe

Address

1263 Linden Ave Arbutus

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof

Mar. 13, 1946  
(month) (day) (year)

Cemetery or crematory

Western

Location

Baltimore, md

18. Funeral director

2113 Oak St

Address

1217 St Paul St, Balt, Md

19. 3-11

(Date rec'd by registrar)

19 46

W. Frederick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 9 19 46 at 5:15 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct. 15 19 45 to March 9 19 46and that I last saw him alive on 2/12/46 19 46

Immediate cause of death

Chronic Myocarditis

DURATION

6 months

Due to

Chronic Myocarditis & Coronary Insufficiency

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Eliot W Johnson

M. D. or other

Address

3432 Frederick Ave

Date signed

3/9/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-2

02431

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltoCity or town Essex  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

417 Dorsey Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltoCity or town Essex  
(If outside city or town limits, write RURAL and give nearest town)Street No. 417 Dorsey Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Francis John Rafay

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced single6. (b) Name of husband or wife -7. Birth date of deceased (mo., day, yr.) July 7-1929 6. (c) If alive, give age - years8. AGE: Years 16 Months 8 Days - If less than one day - hrs. - min.9. Birthplace Verona Pa.  
(Town, county, and state)10. Usual occupation Schoolboy11. Industry or business -12. Name Frank Rafay13. Birthplace Austria14. Maiden name Helen Kuczynski15. Birthplace Pittsburgh Pa.16. Informant Frank RafayAddress 417 Dorsey Ave.17. Burial Date thereof March 15, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Sacred HeartLocation Berman Hill Rd.18. Funeral director John H. ConnellyAddress 418 Eastern Ave. Essex 2119. 3/13/46 John H. Connelly  
(Date rec'd by registrar) (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 12 19 46 at - M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10 19 46 to March 12 19 46and that I last saw him live on March 12 19 46Immediate cause of death osteogenic sarcoma  
of left femur

DURATION

6 mo

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Essex Md. Date signed 3/13/46

RECEIVED  
MAR 22 1946  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Bacon  
Taylor Ave.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124-6)

## CERTIFICATE OF DEATH

02432

Reg. Dist. No. 98

### 1. PLACE OF DEATH:

County Carney  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Harford Road & Summitt Avenue

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carney  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Harford Road & Summitt Avenue  
(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (a) FULL NAME

Emma C. Roberts

### 3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife George W. Roberts

7. Birth date of deceased (mo., day, yr.) August 5th, 1872

8. AGE: Years 73 Months 7 Days 16 If less than one day hrs. min.

9. Birthplace Penna.  
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

FATHER 12. Name Martin Miller

13. Birthplace Germany

MOTHER 14. Maiden name Margaret ?

15. Birthplace Germany

16. Informant Mr. George W. Roberts

Address Harford Road & Summitt Avenue

17. Burial Burial Date thereof 3/25/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parkwood Cemetery

Location Baltimore, Maryland

18. Funeral director Leonard J. Ruck

Address 5305 Harford Road -14-

19. 3/21 19 46 A. M. Bacon  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 21st, 19 46 at 1:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 19 46 to March 21 19 46 and that I last saw him alive on March 20 19 46

Immediate cause of death

Left hemiplegia

DURATION

16 days

Due to

Arteriosclerosis and hypertension

8 yrs +

Due to

Other conditions

Myocarditis  
cirrhosis of liver  
(Include pregnancy within 3 months of death)

1 yr +

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE A. M. Bacon M.D. M. D. or other

Address 2810 Taylor Ave Date signed 3/21/46

RECEIVED  
MAR 23 1946  
BUREAU V.S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County..... Baltimore  
City or town..... Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... One day  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp.  
How long in hospital or institution?..... One day

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Baltimore  
City or town..... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 1931 Edgemere Avenue  
(If rural, give LOCATION)  
2. (a) If veteran, name war: World War I

### 3. (a) FULL NAME

ALEXANDER J. ROBERTSON

### 3. (b) Social Security Number

048-03-5439

4. Sex..... Male 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Married

6. (b) Name of husband or wife..... Estelle Robertson  
6. (c) If alive, give age..... unknown years

7. Birth date of deceased (mo., day, yr.)..... March 23, 1878

8. AGE: Years..... 68 Months..... - Days..... 7 If less than one day..... hrs. .... min.

9. Birthplace..... Scotland  
(Town, county, and state)

10. Usual occupation..... Bank Manager

11. Industry or business.....

12. Name..... John B. Robertson

13. Birthplace..... Scotland

14. Maiden name..... Margaret Mortimer Johnston

15. Birthplace..... Scotland

16. Informant..... Clinical Records, Vets. Adm. Hosp.  
Address..... Fort Howard, Maryland

17. (Burial, cremation, or entombment. Which?)..... Burial Date thereof..... April 3-1946

Cemetery or crematory..... Lyons Hill

Location..... Laurel and

18. Funeral director..... The H. C. White Co. Inc.

Address..... Laurel and

19. (Date rec'd by registrar)..... 3/30 19..... 46 City Health Dept.

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 30 19..... 46 at..... 7:00 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....  
and that I last saw him..... alive on..... March 30 19..... 46

Immediate cause of death..... CORONARY THROMBOSIS, ACUTE

#### DURATION

Sudden

Due to..... HYPERTENSION, ARTERIAL

Due to.....

Other conditions..... ABDOMINAL MASS, TYPE  
UNDETERMINED  
(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... A. M. BALTER, LT. COL. U.S. Clin.  
Fort Howard, Md.

Address..... Date signed..... 3-31-46

MARGIN RESERVED FOR BINDING

VS A15

9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 1 1946

BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 102

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

02434

### 1. PLACE OF DEATH

County... Baltimore  
City or town... Bumdark 22 mi  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?... Life  
Hospital, institution, or street address where death occurred: \_\_\_\_\_

How long in hospital or institution? \_\_\_\_\_

### 3. (a) FULL NAME

Violotta Mary Rollins

### 3. (b) Social Security Number

4. Sex

F

5. Color or race

col

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Feb 8, 1946

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State... MD County... Baltimore  
City or town... Bumdark 22 mi  
(If outside city or town limits, write RURAL and give nearest town)  
Street No... 22 Cottage Ave  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

### MEDICAL CERTIFICATION

20. DATE OF DEATH... March 22<sup>nd</sup> 1946 at... 44 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 20<sup>th</sup> 1946 to March 22<sup>nd</sup> 1946

and that I last saw him/her alive on March 20<sup>th</sup> 1946

Immediate cause of death... For far pneumonia

Due to... Malnutrition

Other conditions... Malnutrition

(Include pregnancy within 3 months of death)

Major findings of operations... None

Date of op... \_\_\_\_\_

Autopsy results... \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE: John Thomas M.D.

M. D. or other \_\_\_\_\_

Address... Burner's Sta md Date signed 3/22/46

MARGIN RESERVED FOR BINDING

I

T

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NAVY AND DEPARTMENT OF HEALTH

RECEIVED

RECEIVED

APR 3 1946

BUREAU V.S.

OFFICE OF THE SURGEON GENERAL

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-6

## CERTIFICATE OF DEATH

02435

P

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County Balto.City or town Todds Farm Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Todds Farm Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)Street No. Sparrows Point  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Henry Ruley

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower6. (b) Name of husband or wife Sophie Ruley7. Birth date of deceased (mo., day, yr.) Nov. 22-1887 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 58 Months 3 Days 9 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Balto. Md.  
(Town, county, and state)  
Retired Policeman

10. Usual occupation

11. Industry or business

FATHER 12. Name George Ruley13. Birthplace Balto. Md.MOTHER 14. Maiden name Elizabeth Smith15. Birthplace Balto. Md.16. Informant Mrs. Nettie HerminauAddress Todds Farm Nr. Fort Howard17. Burial Burial Date thereof Mar. 7/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Sacred Heart Cem.Location German Hill Road  
John A. Miller

18. Funeral director

Address 2334 Jefferson St.19. 3-7 19 46 Unrecorded  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 19 46 at 7 a M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 46 to March 4 19 46 and that I last saw him alive on March 2 19 46

Immediate cause of death

Pulmonary T.B.P. DURATION 7

Due to

Due to

Other conditions P. Kuss's choke Heart dis. ?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [Signature] M. D. or otherAddress 520 D St. S.W. Date signed 3.4.46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02436 30

Reg. Dist. No.

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 month, 14 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 1 month, 14 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore-24  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 607 South Clinton Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Andrew Saal

## 3.(b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Elizabeth Dombroski 6.(c) If alive, give age 83 years  
 7. Birth date of deceased (mo., day, yr.) October 16, 1866  
 8. AGE: Years 79 Months 4 Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Germany  
 (Town, county, and state)  
 10. Usual occupation Laborer  
 11. Industry or business Factory  
 12. Name Joseph Saal  
 13. Birthplace Germany  
 14. Maiden name Laura Britting  
 15. Birthplace Germany  
 16. Informant Hospital records  
 Address Catonsville-28, Md.

17. Burial Date thereof 3/4/46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Sacred Heart  
 Location German Hill Road  
 18. Funeral director Lilly & Zeiler inc.  
 Address 403 S. Wolfe st.  
 19. March 2, 46 A.W. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 1 19 46 at 3:25 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 15 19 46 to March 1 19 46  
 and that I last saw him alive on March 1 19 46

Immediate cause of death Terminal broncho pneumonia DURATION 2 days

Due to Arteriosclerotic cardiovascular disease Indef.

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_

Autopsy results none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other \_\_\_\_\_  
 Address Catonsville-28, Md. Date signed 3-1-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02437

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, Md.How long in hospital or institution? 9 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1305 Cambria St.  
(If rural, give LOCATION)2.(a) If veteran, name war VN-I

## 3. (a) FULL NAME

THURSTON L. SALLY

## 3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>white</u>	6.(a) Single, married, widowed, or divorced <u>married</u>
-----------------------	----------------------------------	---

6.(b) Name of wife Maggie Sally6.(c) If alive, give age 46 years7. Birth date of deceased (mo., day, yr.) 9-7-97

8. AGE:	Years	Months	Days	If less than one day
	<u>48</u>	<u>6</u>	<u>21</u>	.....hrs. ....min.

9. Birthplace South Carolina  
(Town, county, and state)10. Usual occupation Pipe Fitter

11. Industry or business

12. Name Oscar Sally13. Birthplace South Carolina14. Maiden name Alma E. Boyleston15. Birthplace South Carolina16. Informant Clinical Records, Vets. Adm. Hosp.  
Address Ft. Howard, Md.17. Buried Date thereof March 30/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore NationalLocation Ft. Howard, Md.18. Funeral director Olds Funeral Home Inc.Address 4644 YORK RD19. 3-29 19. 46  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 19. 46, at 8:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19, 19. 46, to March 28, 19. 46  
and that I last saw him alive on March 28, 19. 46Immediate cause of death Ventricular Paroxysmal Tachycardia DURATION 2 Mos.Due to DISEASE OF THE HEART:  
Cause: Coronary Arteriosclerosis  
S.L.: Coronary Occlusion  
Manif: Ventricular tachycardia  
Intraventricular block

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A.M. BalterA.M. BALTER, LT. COL., M.C. CLIN. DIR.  
Address Ft. Howard, Md. Date signed 3-28-46



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 982

## CERTIFICATE OF DEATH bc

02438

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 day  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1026 East Fort Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mollie Schaeffer

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife ?  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) July 17, 1885  
 8. AGE: Years 60 Months 7 Days 24 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Germany  
 (Town, county, and state)  
 10. Usual occupation Matron  
 11. Industry or business ?  
 12. Name ?  
 13. Birthplace ?  
 14. Maiden name ?  
 15. Birthplace ?

MOTHER FATHER

16. Informant Hospital records  
 Address Catonsville-28, Maryland  
 17. Burial Date thereof 3/16/46  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Western Cemetery  
 Location Balto, Md.  
 18. Funeral director Chas. F. Dill  
 Address 1001 E. Fort Ave.  
 19. 3/16 46 AW Hedrick  
 (Date rec'd by registrar) (year) Registrar phl

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 19 46 at 9:00 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_  
 and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Acute Cardiac failureDue to Cardiovascular disease

Due to \_\_\_\_\_

Other conditions sudden death

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Dr. M. Schaeffer Chas. F. Dill

M. D. or other

Address 1010 Leeds Ave Date signed 3-13-46

Rec'd V.S.  
3/16/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02439

Reg. Dist. No. 33

## 1. PLACE OF DEATH:

County..... Baltimore

City or town..... Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

129 N. Symington Avenue

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County.....

City or town..... Catonsville  
(If outside city or town limits, write RURAL and give nearest town)Street No..... 129 Symington Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Donald J. Schapperle

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

7. Birth date of

deceased (mo., day, yr.)

March 19, 1944

8. AGE:

Years

Months

Days

It less than one day

1

11

29

.....hrs. ....min.

9. Birthplace..... Baltimore, Maryland

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER

12. Name..... Charles R. Schapperle

13. Birthplace..... Maryland

MOTHER

14. Maiden name..... Josephine M. Restivo

15. Birthplace..... New York

16. Informant..... Mr. Charles R. Schapperle

Address..... 129 N. Symington Avenue

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof..... March 21, 1946  
(month) (day) (year)

Cemetery or crematory..... New Cathedral Cemetery

Location..... 4300 Old Frederick Road

18. Funeral director..... Harry H. Rutledge

Address..... 4101 Edmondson Avenue

19. B-20 - 46  
(Date rec'd by registrar)

19

46

Harry H. Rutledge  
Deputy Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH..... March 18, 1946, at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 28, 1946 to March 18, 1946

and that I last saw him alive on March 18, 1946

Immediate cause of death.....

Acute Lymphatic Leukemia

DURATION

7 wks?

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

3030 Edmondson Ave.

M. D. or other

Date signed 3/19/46

CERTIFICATE OF DEATH

RECEIVED

MAR 25 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

02440

Reg. Dist. No. 307

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Calonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 13 yrs - 4 mo - 10 day  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital Calonsville  
 How long in hospital or institution? 13 yrs - 4 mo - 10 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BALTO.  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 12 N. Kresson St.  
 (If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Henry A. Schenning

## 3. (b) Social Security Number

NONE

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male white single

8. (b) Name of husband or wife

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1907

8. AGE: Years Months Days If less than one day  
38 11 12 hrs. min.

9. Birthplace Baltimore Md.  
 (Town, county, and state)

10. Usual occupation wood worker in lumber mill

11. Industry or business

Wood veneering12. Name August Schenning13. Birthplace New York State14. Maiden name CATHERINE FAULSTICH15. Birthplace Baltimore, Md.

16. Informant father August Schenning  
 Address 12 No. Kresson St Baltimore Md

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof MAR. 13/46  
 (month) (day) (year)

Cemetery or crematory SACRED HEARTLocation GERMAN HILL ROAD18. Funeral director Lilly & Zeiler Inc.Address 403 S. WOLFE ST.

19. 3/12 46 A. W. Hedrick  
 (Date read by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 10, 1946 at 6<sup>02</sup> P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Dec. 15 1945 to Mar 10 1946  
 and that I last saw him alive on March 10 1946

Immediate cause of death

Terminal Bronchopneumonia 48 hrs  
l. lower lobe

Due to

Due to

Other conditions

Epilepsy

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. of

Address Spring Grove Hospital Date signed Mar 10-46  
Calonsville 28 Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (732)

## CERTIFICATE OF DEATH

02441

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County Baltimore - 27City or town ABUTUS  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1265 Stevens Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore 27City or town ABUTUS  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1265 Stevens Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Elizabeth Schmidt - "Schmidt"

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married8. (b) Name of husband or wife George J. Schmidt6. (c) If alive, give age 68 years7. Birth date of deceased (mo., day, yr.) 10/26/1880

8. AGE: Years Months Days If less than one day

65 4 11 hrs. min.9. Birthplace Baltimore, Md.

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business At Home12. Name John J. Schmidt13. Birthplace Maryland14. Maiden name Leagisima ?15. Birthplace Maryland16. Informant Dr. George J. SchmidtAddress 1265 Stevens Ave17. Burial Date thereof 3/12/46

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Baltimore CemeteryLocation Baltimore, Md.18. Funeral director St. B. Thayer & SonAddress 1300 East Ave19. 3/12 19 46 A. W. Hedrick

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1946 at 125 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 19 43 to March 9 19 46and that I last saw him alive on March 9 19 46

Immediate cause of death

arteriosclerotic heart disease DURATION 6 yrs.Acute Pulmonary edema 1 1/2 hrs.Due to Chronic Cardiac Insufficiency 6 yrs.Due to Coronary Arteriosclerosis 6 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Earl Pass, M.D. M. D. or otherAddress 4001 Wilkens Ave Date signed March 10, 1946



02442 31  
Reg. Diat. No. ....

Address 2220 Garrison Blvd. Date signed 4/17/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02443

Reg. Dist. No. 31

1. PLACE OF DEATH: **Baltimore**  
 County.....  
 City or town.....**Randallstown**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....**Md.**..... County.....  
 City or town.....**Randallstown**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....**Randallstown**  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
**Albert R. Schreiber**

3. (b) Social Security Number

4. Sex **Male** 5. Color or race **White** 6.(a) Single, married, widowed, or divorced **Married**

6.(b) Name of husband or wife **Elizabeth Simon Schreiber**

7. Birth date of deceased (mo., day, yr.) **Jan. 2, 1869.** 8.(c) If alive, give age..... years

8. AGE: Years **77** Months **2** Days **17** If less than one day  
 hrs. min.

9. Birthplace **Germany**  
 (Town, county, and state)

10. Usual occupation **Retired**

11. Industry or business

FATHER 12. Name **Schreiber**  
 13. Birthplace **Germany**

MOTHER 14. Maiden name **Unknown**  
 15. Birthplace **Germany**

16. Informant **Joseph Schreiber**  
 Address **Randallstown, Md.**

17. **Burial** Date thereof **March 21/46.**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory **Mt. Olive**  
**Randallstown, Md.**  
 Location

18. Funeral director **Harry H. Witzke**  
 Address **4101 Edmondson Ave.**

19. **3-21** 19 **46**  
 (Date rec'd by registrar) Registrar **Asw. Hedrick**  
**adk**

## MEDICAL CERTIFICATION

20. DATE OF DEATH **March 19<sup>th</sup> 1946** at **10:30** A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Feb. 1945** to **March 19<sup>th</sup> 1946** and that I last saw him alive on **March 19<sup>th</sup> 1946**

Immediate cause of death..... DURATION

**Carcinoma of Urinary Bladder 6 mos.**  
 Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)  
 Major findings of operations **Ca. of Urinary Bladder**  
 Date of op. **1945**

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE **James A. Miller, Jr.** M. D. or other

Address **Pikesville, Md.** Date signed **3/20/46**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH *bc*02444 37  
Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Cockeysville Ind  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 yrs 9 months  
 Hospital, institution, or street address where death occurred:  
Masonic Home, Cockeysville Ind  
 How long in hospital or institution? 10 yrs, 9 months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County .....  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1810 W Lombard St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Mrs Frances R. Scott

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow  
 6.(b) Name of husband or wife Wm. Robert Scott  
 6.(c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) April 25 - 1860  
 8. AGE: Years 85 Months 10 Days 9 It less than one day  
 ..... hrs. .... min.

9. Birthplace Baltimore Ind  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business

FATHER 12. Name Washington Head Nicholson  
 13. Birthplace Unknown

MOTHER 14. Maiden name Francois Cornelia Cartier  
 15. Birthplace Whitehall N. Y.

16. Informant Laura M. Schneider  
 Address Masonic Home, Cockeysville Ind

17. Burial Date thereof Mar. 9 - 46  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lorraine Park  
 Location Baltimore Ind

18. Funeral director Geo. L. Beyer Jr.  
 Address 1512 Hollins St

19. Mar. 7 19 46 L.M. Schneider  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 19 46 at 7:10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 19 37 to March 6 19 46  
 and that I last saw him alive on March 6 19 46

Immediate cause of death Cardiac Decompensation DURATION 1 week

Due to Generalized Arterio Sclerosis 4 yrs

Due to Diabetes Mellitus 5 yrs

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Wilbur F. Skillman M.D.  
6 E. Biddle St M. D. or other

Address 6 E. Biddle St Date signed 3/6/46

RECEIVED

MAR 11 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

02445

## 1. PLACE OF DEATH:

County BaltimoreCity or town Carney  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
Joppa Road near 9th ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Carney  
(If outside city or town limits, write RURAL and give nearest town)Street No. Joppa Road near 9th Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Samuel Lewis Sellers

## 3.(b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>	
6.(b) Name of husband or wife <u>Grace Elizabeth Sellers</u>			
6.(c) If alive, give age <u>47</u> years			
7. Birth date of deceased (mo., day, yr.) <u>February 24, 1884</u>			
8. AGE: Years <u>62</u>	Months <u>-</u>	Days <u>8</u>	If less than one day .....hrs. ....min.

9. Birthplace Randallstown, Md.  
(Town, county, and state)10. Usual occupation Farmer

## 11. Industry or business

12. Name William Sellers13. Birthplace England14. Maiden name Mary Jane Coates15. Birthplace Baltimore, Md.16. Informant Mrs. Samuel L. Sellers  
Address Joppa Rd near 9th Ave.  
Carney, Md.17. Burial Date thereof March 6, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. Olive CemeteryLocation Randallstown, Md.18. Funeral director W. L. MooreAddress 4510 Liberty Heights Ave.19. 3/6 19 46 A.W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 4 19 46, at 9 A. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
July 19 45 to March 19 46  
and that I last saw him alive on February 27 19 46

Immediate cause of death

Chronic Myocarditis 1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. W. Peake M.D. M. D. or otherAddress 4508 Harford RoadDate signed 3. 4. 46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 02446 37

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Elzen Aron Notch Cliff Rd.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 1/2 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Elzen Aron  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Notch Cliff Rd.  
 (If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Charles Herbert Shugars

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Mary Shugars6. (c) If alive, give age 63 years7. Birth date of deceased (mo., day, yr.) March 10, 18948. AGE: Years 52 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Virginia  
(Town, county, and state)10. Usual occupation Tractor11. Industry or business Schenectady Public Co.12. Name Wm. Shugars13. Birthplace Virginia14. Maiden name Elizabeth ?15. Birthplace Virginia16. Informant Mary ShugarsAddress 317 W 30 St.17. Burial Date thereof May 13/46  
(Burial, cremation, or removal-Which?) (month) (day) (year)Cemetery or crematory London ParkLocation Fredrick Road18. Funeral director Chenoweth & SonovareAddress 3615-17 Chestnut Ave, Balto19. 3/11 86 S. W. Sedrick  
(Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 10, 1946 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_\_,

and that I last saw him \_\_\_\_\_ 19\_\_\_\_\_,

Immediate cause of death Heart disease chroniccoronary disease with occlusionChronic myocarditis

## DURATION

1 day3 y. 6 m.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Bollin C. Hudson M.D., D.M.F.Address Towson 4, Md. Date signed 3/10/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

02447

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 69 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, MarylandHow long in hospital or institution? 69 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 609 Sedgwick St.  
(If rural, give LOCATION)2. (a) If veteran, name war WW-I

## 3. (a) FULL NAME

DAVID W. SLOAN

## 3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	--

6. (b) Name of husband or wife Mary E. Sloan6. (c) If alive, give age 49 years7. Birth date of deceased (mo., day, yr.) 11-25-96

8. AGE:	Years	Months	Days	If less than one day
	<u>49</u>	<u>3</u>	<u>16</u>	..... hrs. .... min.

9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Lawyer

## 11. Industry or business

12. Name David W. Sloan13. Birthplace Maryland14. Maiden name Mary Good15. Birthplace Virginia16. Informant Clinical Records, Vets. Adm. Hosp.Address Ft. Howard, Maryland17. Burial Date thereof Feb. 16/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose HillLocation Cumberland Md18. Funeral director Sam SteinAddress Cumberland Md19. 3-14 46 W Sedgwick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 13, 1946 19..... at 7:35 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 3, 1946 to March 13, 1946 and that I last saw him alive on March 13, 1946Immediate cause of death Meningitis, tuberculous DURATION 3-9-46Due to Tuberculosis, chr. pul. far. advanced

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A.M. Balter  
A.M. BALTER, LT. COL., M.C. M.D. IN CH.  
Address Ft. Howard, Maryland Date signed 3-14-46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 0244844

### 1. PLACE OF DEATH:

County Baltimore  
City or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 326 Days  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hosp. Fort Howard, Maryland  
How long in hospital or institution? 326 Days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Westport  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2605 Forester Ave. (If rural, give LOCATION)  
2(a) If veteran, name war WW-2

### 3. (a) FULL NAME

ROBERT M. SMALLWOOD

### 3. (b) Social Security Number

219-22-3133

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife Single

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 3-14-1926

8. AGE: Years 20 Months 0 Days 7 If less than one day hrs. min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

12. Name Robert Smallwood

13. Birthplace Akron, Ohio

14. Maiden name Marian Hill

15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.  
Address Fort Howard, Maryland

17. Burial Date thereof 3-25-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Balto. National

Location Balto, Md.

18. Funeral director Charles R. Law

Address 802 Mad. Ave.

19. 3-25 46 A. W. Hadrach  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 22, 1946 at 5:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30, 1945 to March 22, 1946 and that I last saw him alive on March 22, 1946

Immediate cause of death Generalized Tuberculosis DURATION 4-30-45  
plus

Due to Pulmonary and Osseous tuberculosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. M. Baltes

A. M. BALTES, LT. COL., M.C. MORTUARY

Address Fort Howard, Maryland Date signed 3-22-46

MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *272*CERTIFICATE OF DEATH *bc*

02449

Reg. Dist. No. *30*

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 years, 8 months, 22 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 3 years, 8 months, 22 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2509 Harlen Avenue  
 (If rural, give LOCATION) ✓  
 2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Lorenzo Cline Smith

## 3.(b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced separated  
 6.(b) Name of husband or wife Esther Lorraine Shaw 6.(c) If alive, give age 46 years  
 7. Birth date of deceased (mo., day, yr.) December 17, 1897  
 8. AGE: Years 48 Months 2 Days 17 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Caroline County, Maryland  
 (Town, county, and state)  
 10. Usual occupation unemployed  
 11. Industry or business none  
 FATHER 12. Name Charles Fletcher Smith  
 13. Birthplace Maryland  
 MOTHER 14. Maiden name Caroline Cline  
 15. Birthplace Maryland

16. Informant Hospital records  
 Address Catonsville-28, Maryland  
 17. Burial Date thereof May 9<sup>th</sup> 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory North Cemetery  
 Location North Catonsville, Md.  
 18. Funeral director Bertman & Co.  
 Address 2224 N. Charles St.  
 19. 3/8 19 46 A. W. Hedrick  
 (Date filed by registrar) (year) (month) (day) Registrar D.M.

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 6 19 46 at 8:00 p. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
June 12 19 42 to March 6 19 46  
 and that I last saw him alive on March 6 19 46  
 Immediate cause of death \_\_\_\_\_ DURATION  
Broncho pneumonia, left 72 hours  
lower lobe -  
 Due to Multiple sclerosis - Indefinite  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)  
 Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results as above  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 Signature Isadore Tuerk, M.D. M. D. or other  
 Address Catonsville-28, Md. Date signed 3-7-46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

## CERTIFICATE OF DEATH

02450  
Reg. Dist. No. 33

### 1. PLACE OF DEATH:

County Balto.  
City or town Glyndon  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution:  
Stay in hospital or inst. (yrs., or mos., or days) 2yrs  
Stay in this community (yrs., or mos., or days)

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md. County Balto  
City or town Glyndon Ward No.  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No.  
(If rural give LOCATION)  
2(a) IF VETERAN, NAME WAR None

### 3. (a) FULL NAME

Sadie Victoria Smith

### 3. (b) Social Security Number

None

#### 4. Sex

Female

#### 5. Color or race

Colored

#### 6. (a) Single, married, widowed, or divorced

Widowed

#### 6 (b) Name of husband or wife

John Smith

6 (c) If alive, give age \_\_\_\_\_ years

#### 7. Birth date of deceased (mo., day, yr.)

Feb. 28, 1875

#### 8. AGE:

Years 71

#### Months

#### Days

16

#### If less than one day

hrs. \_\_\_\_\_ min.

#### 9. Birthplace

Balto. Co.

(Town, county, and state)

#### 10. Usual occupation

Housewife

#### 11. Industry or business

#### FATHER

#### 12. Name

Joseph Smith

#### 13. Birthplace

Md.

#### MOTHER

#### 14. Maiden name

Francis Derricks

#### 15. Birthplace

Md.

#### 16. Informant

Effie Berry

#### Address

Glyndon, Md.

#### 17.

Burial

(Burial, cremation, or removal, Which?)

#### Date thereof

Mar. 19, 1946

(month) (day) (year)

#### Cemetery or crematory

Piney Grove

#### Location

Balto. Co.

#### 18. Funeral director

J.F. Eline & Sons

#### Address

Reisterstown, Md.

#### 19.

3-19

19 46

(Date rec'd by registrar)

Dary B. Eline

Registrar

### MEDICAL CERTIFICATION

#### 20. DATE OF DEATH

3-16-

19 46

at 3:4 AM

#### 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-1- 19 40 to 3-16- 19 46  
and that I last saw her alive on 3-14-46 19

#### Immediate cause of death

Myocarditis (chronic)  
decompensating  
arteriosclerosis

#### DURATION

#### Due to

#### Due to

#### Other conditions

(Include pregnancy within 8 months of death)

#### Major findings:

#### Of operations

#### Of autopsy

#### PHYSICIAN

Please underline the cause to which death should be charged statistically.

#### 22. VIOLENCE: If death was due to external causes, fill in the following:

#### Accident, suicide, or homicide

#### Date of

#### Where did injury occur?

(City or town)

(County)

(State)

#### Injured at home, farm, industry, public place (where?)

#### Means of injury

#### Injured at work?

#### 23. SIGNATURE

James S. Saffell

M. D. or other

#### Address

Reisterstown, Md.

Date signed 3/17/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAR 20 1946  
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02451

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County... Ba. 180City or town... Parryville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 22 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County...City or town... Parryville Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2226 Foster Ave.  
(If rural, give LOCATION)

2 (a) If veteran, name war...

## 3. (a) FULL NAME

Walter B. Smith

## 3. (b) Social Security Number

4. Sex M5. Color or race W

6. (a) Single, married (widowed, or divorced)

6. (b) Name of husband or wife... IDA H SMITH

6. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) January 15-18638. AGE: Years 83 Months Days If less than one day hrs. min.9. Birthplace... Ba. 180 Md.  
(Town, county, and state)10. Usual occupation... Retired

11. Industry or business

12. Name... John C. Smith13. Birthplace... England14. Maiden name... Catherine A. Howling15. Birthplace... Phila. Pa.16. Informant... Mrs. Nellie E. BullAddress... 2326 Foster Ave.17. Buried Date thereof... 4-2-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Ba. 180 CemeteryLocation... Ba. 180 Md.18. Funeral director... Leander FinchAddress... 2305 Hampden Road19. 3/31 46 G.W. Bacon  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... March 31 19 46, at 8:15 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from none 19... to 19...

and that I last saw h... alive on 19...

Immediate cause of death... Found dead.

DURATION

Heart disease - coronaryDue to... occlusion

Due to...

Other conditions...

(Include pregnancy within 8 months of death)

Major findings of operations...

Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

A. M. Bacon, M.D. by  
authority of R.C. Hudson, M.D. - D.M.B.

23. SIGNATURE... M. D. or other

Address... 2810 Taylor Ave. Date signed... 3/31/46



RI  
APR 2 1946  
BUREAU V R

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BALTIMORE CITY HEALTH DEPARTMENT

# CERTIFICATE OF DEATH

Registered No. 42

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 1823 Mayfield Ave.(c) Hospital or institution: Halethorpe 27,

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) 2 wks.

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Id. (b) County(c) City or town Baltimore  
(If outside city or town limits, write RURAL and give town)(d) Street No. 3831 Wilkens Ave.  
(If rural give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

## 3 (a) FULL NAME

Elizabeth H. Snyder

3 (b) If veteran, name war

3 (c) Social Security Account

No.

4. Sex

5. Color or race

6 (a) Single, married, widowed, or divorced

Married6 (b) Name of husband or wife W. Harvey Snyder6 (c) If alive, give age 74 years7. Birth date of deceased (mo., day, yr.) July 2, 19728. AGE: Years 73 Months 8 Days 15 hr. min.

If less than one day

9. Birthplace Seven Vallys, Pa.

(Town, county, and state)

10. Usual Occupation House Wife

11. Industry or business

12. Name T. F. Hetrick13. Birthplace Sticks, Pa.14. Maiden Name Josephine Wentz15. Birthplace Pa.16 (a) Informant Mr. W. Harvey Snyder(b) Address 3831 Wilkens Ave.17 (a) Burial (b) Date thereof Mar. 20, 1946

(Burial, cremation, or removal)

(month) (day) (year)

(c) Cemetery or crematory St. JacobsLocation Glenville, Pa.18 (a) Funeral director Frederick A. Cole(b) Address 1200 W. Lombard St.19 (a) Mar. 20, 46 H. K. Heffner

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 17, 1946, at 8:40 AM21. I certify that death occurred on the date above stated; that I attended deceased from July 10, 1945, to Mar 17, 1946, and that I last saw him alive on Mar 17, 1946.

Immediate cause of death

Carcinoma of Cecum

Duration

?

Due to

Due to

Other Conditions Arterio ScleroticCardio Vascular Disease

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?  
(City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work?

(Specify type of place)

(c) Means of injury

23. Signature Carl P. KroschAddress 1316 W. Lombard St. Date signed 3/19/46

## PHYSICIAN

Underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02453

Reg. Dist. No. 17

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 149 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, MarylandHow long in hospital or institution? 149 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 733 W. Saratoga Street  
(If rural, give LOCATION)2.(a) If veteran, name war WW-I

## 3.(a) FULL NAME

JESSE SPRIGGS

## 3.(b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>Colored</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>	
6.(b) Name of husband or wife <u>Mrs. Viola Spriggs</u>			
6.(c) If alive, give age <u>40</u> years			
7. Birth date of deceased (mo., day, yr.) <u>10-3-1889</u>			
8. AGE: Years <u>56</u>	Months <u>5</u>	Days <u>6</u>	If less than one day .....hrs. ....min.

9. Birthplace Baltimore, Md.  
(Town, county, and state)10. Usual occupation Helper--Driver

11. Industry or business

12. Name Jesse Spriggs

13. Birthplace Maryland

14. Maiden name Rebecca Gross

15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.  
Address Ft. Howard, Md.17. Burial Date thereof March 13, 1946  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Brook's ChapelLocation Mutual, Calvert Co., Md.18. Funeral director Mrs. Frances A. HemsleyAddress 578 W. Biddle St.19. 3-11 1946  
(Date rec'd by registrar) ack Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 9, 1946 at 6:15 A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
October 11, 1945 to March 9, 1946  
and that I last saw him alive on March 9, 1946Immediate cause of death  
Carcinoma of the StomachDURATION  
Unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. M. Balter Don  
A. M. BALTER, LT. COL., M.C. CLIN. DIR.Address Ft. Howard, Md. Date signed 3-9-46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BPA)

## CERTIFICATE OF DEATH

02454

Reg. Dist. No. 38

### 1. PLACE OF DEATH:

County Calverton

City or town Carney  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Baltimore

City or town Carney  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9635 Dixie Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Emilie Virginia Stevens

### 3. (b) Social Security Number

none

#### 4. Sex

Female

#### 5. Color or race

White

#### 6. (a) Single, married, widowed, or divorced

Widow

#### 6. (b) Name of husband or wife

Thomas Stevens

#### 7. Birth date of deceased (mo., day, yr.)

April 4, 1872

#### 6. (c) If alive, give age

years

#### 8. AGE:

Years 73

Months 11

Days 22

If less than one day

hrs. 1

min.

#### 9. Birthplace

Kent Co. Md.  
(Town, county, and state)

#### 10. Usual occupation

Housewife

#### 11. Industry or business

#### FATHER

#### 12. Name

Nicholas Drees

#### 13. Birthplace

Unknown

#### MOTHER

#### 14. Maiden name

Unknown

#### 15. Birthplace

Unknown

#### 16. Informant

Margaret Stevens

#### Address

9635 Dixie Ave. Carney MD

#### 17.

(Burial, cremation, or removal. Which?)

#### Date thereof

3/28/46  
(month) (day) (year)

#### Cemetery or crematory

Stevensville

#### Location

Queen Anne's Co. Md.

#### 18. Funeral director

William Cook Inc

#### Address

1217 St. Paul St.

#### 19.

3/27 19 46  
(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 26, 19 46, at Carney M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 19, 19 46, to Mar. 26, 19 46 and that I last saw her alive on March 26, 19 46

#### Immediate cause of death

Acute myocardial infarction

#### DURATION

1

#### Due to

Generalized arteriosclerosis

#### Due to

Gangrene, Right foot

#### Other conditions

Chronic nephritis

(Include pregnancy within 3 months of death)

#### Major findings of operations

#### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

#### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

#### 23. SIGNATURE

Nathan Janney MD

M. D. or other

Address 7101 Harford Rd Date signed 3/26/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02455

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

### 1. PLACE OF DEATH:

County Baltimore

City or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

7418 Windsor Mill Road

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Woodlawn  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 7418 Windsor Mill Road

(If rural, give LOCATION)

2.(a) If veteran, name war

### 3.(a) FULL NAME

Charles E. Subock

### 3.(b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife Margaret Ann Subock

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

February 8, 1865

8. AGE:

Years

Months

Days

If less than one day

81

1

11

hrs.

min.

9. Birthplace Baltimore County, Md.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name John Subock

13. Birthplace

Germany

MOTHER

14. Maiden name Josephine Schaible

15. Birthplace

Baltimore County, Md.

16. Informant Mrs. Edna Piel

Address 7418 Windsor Mill Road, Wdln, Md.

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

March 22, 1946  
(month) (day) (year)

Cemetery or crematory

Mt. Olive Cemetery

Location

Randallstown, Md.

18. Funeral director

Address

4510 Liberty Heights Ave.

19.

3-21

19

46

(Date rec'd by registrar)

Art. Heston  
ask

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 19 19 46 at 2:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 44 to March 19 19 46  
and that I last saw him alive on March 19 19

Immediate cause of death

Coronary artery disease

Due to

arteriosclerosis

Due to

hypertension

Other conditions

chronic bronchitis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. C. Smith

M. D. or other

Address 4509 Liberty Hgts Ave.

Date signed March 19

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

02456

## CERTIFICATE OF DEATH

Reg. Dist. No. 90

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hood's Nursing Home, 5501 Edmondson Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ma. CountyCity or town Arbutus  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1210 Elmridge Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Mary Anna Thornton

## 3.(b) Social Security Number

4. Sex Female 5. Color or race W. 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Late Patrick Thornton

7. Birth date of deceased (mo., day, yr.) Nov. 22, 1855. 6.(c) If alive, give age years

8. AGE: Years 90 Months 3 Days 14 If less than one day  
 hrs. min.

9. Birthplace Maryland  
 (Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name John Foeller13. Birthplace Germany14. Maiden name Margaret Krone15. Birthplace Germany16. Informant Mortimer ThorntonAddress 1210 Elmridge Rd.

17. Burial Date thereof March 12/46.  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Loudon ParkLocation 3801 Frederick Rd.18. Funeral director Harry H. WitzkeAddress 4101 Edmondson Ave.

19. 5-12 46 Harry D. Miller  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 8 1946 at 11:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 36 to March 8 1946  
 and that I last saw her alive on March 8 1946

Immediate cause of death Crown Thromboses DURATION 1 day

Due to Chronic Myocardial C Coronary Thromboses 8 years

Due to General Arteriosclerosis 10 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Cliff W. Johnson M.D. or other

3432 Frederick Ave Date signed 3/9/46



RECEIVED BY BUREAU OF HEALTH

CERTIFICATE OF HEALTH

STATE OF NEW YORK

1946

1946

1946

1946

1946

RECEIVED

MAR 14 1946

BUREAU V S

1946

1946

1946

1946

1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH  
2411 N. Charles St., Baltimore 730  
**CERTIFICATE OF DEATH**

★02457  
Reg. Diat. No. 44

FILM No. 101 APR - 9 1946

**1. PLACE OF DEATH:**

County Balto  
City or town Essex  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

2120 Orens Rd.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State md County Balto

City or town Essex  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2120 Orens Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME**

Elizabeth Tudor

**3. (b) Social Security Number**

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Howard Tudor

7. Birth date of deceased (mo., day, yr.) April 1-1877 8.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 68 Months 09 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Germany  
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant Howard Tudor

Address 2120 Orens Rd.

17. Burial Date thereof 4/9/46  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Barkwood

Location Taylor Ave.

18. Funeral director John J. Connelly

Address 418 Eastern Ave. Essex

19. 4/2/46 John J. Connelly Registrar  
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH March 31 19 46 at 11:30 PM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 28 19 46 to March 31 19 46 and that I last saw him alive on March 31 19 46

Immediate cause of death Coronary thrombosis DURATION Sudden

Due to arterio-sclerosis  
cardio-vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. Brown M. D. or other

Address Balto Date signed 4/2/46

RECEIVED

APR 4 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02458

Reg. Dist. No. 40

**1. PLACE OF DEATH:** Chase, Md.  
 County \_\_\_\_\_  
 City or town \_\_\_\_\_  
 (If outside city or town limits, write RURAL NEAR and give town)  
 Street address, hospital, or institution: \_\_\_\_\_  
 Stay in hospital or inst. (yrs., or mos., or days) \_\_\_\_\_  
 Stay in this community (yrs., or mos., or days) \_\_\_\_\_

**2. USUAL RESIDENCE (HOME) OF DECEASED:**  
 (For newborn infants give residence of mother)  
 State \_\_\_\_\_ County \_\_\_\_\_  
 City or town \_\_\_\_\_ Ward No. \_\_\_\_\_  
 (If outside city or town limits, write RURAL NEAR and give town)  
 Street No. 154 B, Route 14, Baltimore 20, Md.  
 (If rural give LOCATION)  
**2(a) IF VETERAN, NAME WAR** \_\_\_\_\_

**3. (a) FULL NAME**

Joseph h Vich

**3. (b) Social Security Number**

none

**4. Sex** male **5. Color or race** white **6. (a) Single, married, widowed, or divorced** widow  
**6 (b) Name of husband or wife** Frances Vich - deceased.  
**6 (c) If alive, give age** \_\_\_\_\_ years  
**7. Birth date of deceased (mo., day, yr.)** April 26, 1860  
**8. AGE:** Years 85 Months 10 Days 12 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
**9. Birthplace** Czechoslovakia  
 (Town, county, and state)  
**10. Usual occupation** Retired  
**11. Industry or business** \_\_\_\_\_  
**FATHER**  
**12. Name** Unknown  
**13. Birthplace** "  
**MOTHER**  
**14. Maiden name** "  
**15. Birthplace** "

**16. Informant** Mary Melka - daughter  
 Address Chase, Md.  
**17. (Burial, cremation, or removal. Which?)** Burial Date thereof 3, 13, 46  
 (month) (day) (year)  
 Cemetery or crematory Holy Redeemer  
 Location Belair Road  
**18. Funeral director** Charles E. Schimunek.  
 Address 2601-03 E. Madison Street  
**19. 3-12-46** 1946  
 (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH** March 10, 1946, at 2 A.M.

**21. I CERTIFY** that death occurred on the date above stated; that I attended deceased from March 1, 1946, to March 10, 1946, and that I last saw him alive on March 10, 1946.

**Immediate cause of death** Arterio-sclerotic Cardio-vascular disease

**DURATION**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

**Major findings:** \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

**22. VIOLENCE:** If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

**23. SIGNATURE** M. B. Gardner

M. D. or other

Address Baltimore Date signed 3-11-46

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

02459

Reg. Dist. No. 40

## 1. PLACE OF DEATH:

County BaltimoreCity or town Perry Hall, Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Walter Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltoCity or town Perry Hall  
(If outside city or town limits, write RURAL and give nearest town)Street No. As in No 1  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Annie E Walter

## 3. (b) Social Security Number

--

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed6. (b) Name of husband or wife George A Walter

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) April 30 18658. AGE: Years Months Days If less than one day  
80 10 22 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Harford County Md  
(Town, county, and state)10. Usual occupation At Home

11. Industry or business

12. Name ----- Smith13. Birthplace Germany14. Maiden name Unknown

15. Birthplace

16. Informant Mr. Fred WalterAddress Perry Hall, Md17. Burial Date thereof Mch 25 46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Michaels Luth CemeteryLocation Perry Hall, Md18. Funeral director Laseahn Funeral HomeAddress 7401 Belair Road19. 3/23/46 19. W. M. Stumm  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mch 22 1946 6:30 AM at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 15 1944 to Mar 22 1946and that I last saw him alive on Mar 22 1946

Immediate cause of death \_\_\_\_\_ DURATION

Acute pulmonary edema 1 dayDue to Chronic myocardial disease 2 yrs.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

Arteriosclerosis 40 yrs.  
(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE A. Lee Hickey

M. D. or other

Address 4116 Northern Parkway Date signed 3/23/46

Dr. Hiclow

RECEIVED

APR 3 1946

BUREAU V. H.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-7

02460

## CERTIFICATE OF DEATH

Reg. Diat. No. 91

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Randallstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Liberty Road  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Baltimore  
 City or town Randallstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Liberty Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary S. Walters

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) September 27, 1857  
 8. AGE: Years 88 Months 5 Days 27 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Randallstown, Md.  
 (Town, county, and state)  
 10. Usual occupation Homemaker  
 11. Industry or business At Home  
 12. Name Samuel B. Walters  
 13. Birthplace Maryland  
 14. Maiden name Anna E. Fryfogle  
 15. Birthplace Baltimore County, Md.

16. Informant Mr. Noah H. F. Walters  
 Address Liberty Rd., Randallstown

17. Burial Date thereof March 27, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Mt. Olive Cemetery  
 Location Randallstown, Md.  
 18. Funeral director Willis Lawrence  
 Address 4510 Liberty Heights Ave.

19. 3/24/1946 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

2D. DATE OF DEATH March 24 19 46, at 9.15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 23, 1946 to Mar 24, 1946  
 and that I last saw him alive on Mar 23, 1946

Immediate cause of death Chronic nephritis  
(interstitial)

DURATION

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
 \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE W. E. Martin M. D. or other  
Randallstown  
 Address Harrisville, Md. Date signed 3/24/46

RECEIVED  
APR 9 1946  
BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

02461

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County BaltimoreCity or town Towson 4, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since May 5, 1944  
Hospital, institution, or street address where death occurred:Eudowood Sanatorium, Towson 4, Md.How long in hospital or institution? Since May 5, 1944

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1900 N Charles St  
(If rural, give LOCATION) ✓

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

John Joseph Ward

## 3. (b) Social Security Number

4. Sex male5. Color or race white6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife.....

8.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) July 8, 1896

8. AGE: Years Months Days If less than one day

49 8 3 ..... hrs. .... min.9. Birthplace Philadelphia  
(Town, county, and state)10. Usual occupation Managers & Billiard Room

11. Industry or business.....

12. Name John J. Ward12. Birthplace Pennsylvania14. Maiden name Margaret Dailey15. Birthplace Pennsylvania

Personal History-Hospital Records

18. Informant Eudowood Sanatorium, Towson 4, Md.Address Eudowood Sanatorium, Towson 4, Md.17. Funeral Date thereof MAR 14-46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CATHEDRALLocation OLD FREDERICK ROAD18. Funeral director CHAS. F. EVANS & SONAddress 118 W. THE TYPICAL AVE19. Mar 12 46 John J. Ward Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 11 19 46 at 7 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 19 44 to March 11 19 46and that I last saw him alive on March 11 19 46

Immediate cause of death.....

Pulmonary tuberculosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

Signature W.A. Bridges M. D. or otherAddress Towson 4, Maryland Date signed 3-11-46

RECEIVED  
MAR 18 1946  
BUREAU V.S.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

03107

## 1. PLACE OF DEATH

County

Baltimore

Village or City

Spawns Point

No.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

St.

Ward

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U.S. if of foreign birth?

yrs.

mos.

ds.

## 2. FULL NAME

Alongs Watkins

(a) Residence: No.

2737 W. Fairmount St., 4th Ward.

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

Gene C. Watkins

6. DATE OF BIRTH (month, day, and year)

April 25, 1896

7. AGE

Years

Months

Days

If LESS than

1 day, hrs. or min.

49

11

1

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

Rail Operator

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

3/26/46

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country)

Maryland

FATHER

13. NAME

Heenning Watkins

14. BIRTHPLACE (city or town) (State or country)

Md.

MOTHER

15. MAIDEN NAME

Mary Beale

16. BIRTHPLACE (city or town) (State or country)

Md.

17. INFORMANT

(Address)

Gene C. Watkins  
2737 W. Fairmount St.

18. BURIAL, CREMATION, OR REMOVAL

Place

Walden Ridge

Date

Mar 29, 1946

19. UNDERTAKER

(Address)

F. B. Shippert & Son  
1300 Eastern Ave.

20. FILED

3-27, 1946

A. J. Feduch  
Regist.

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

Mar.

(Month)

Mar 26

(Day)

193

(Year)

22. I HEREBY CERTIFY, That I attended deceased from Mar 26, 1946, to

last saw h. alive on

to have occurred on the date stated above, at

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Hemiplegia right side

Date of onset

Immediate

Other Contributory Causes of importance:

Hypertension

Name of operation

Date of

What test confirmed diagnosis?

Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of Injury

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed)

(Address)

M. J. McGarvie  
Deputy Medical Examiner

M. D.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 470

## CERTIFICATE OF DEATH

02462

Reg. Dist. No. 45

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 90 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp., Ft. Howard, Md.How long in hospital or institution? 90 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2564 Robb St.  
(If rural, give LOCATION)2.(a) If veteran, name war WW-2

## 3. (a) FULL NAME

FRANK P. WENDLING

## 3. (b) Social Security Number

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
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6. (b) Name of husband or wife Daisy Wendling6. (c) If alive, give age 21 years7. Birth date of deceased (mo., day, yr.) 2-21-09

8. AGE:	Years	Months	Days	If less than one day
	<u>37</u>	<u>0</u>	<u>21</u>	..... hrs. .... min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)10. Usual occupation Auto-mechanic

11. Industry or business

12. Name Faibian Wendling13. Birthplace Germany14. Maiden name Susana Youst15. Birthplace ?16. Informant Clinical Records, Vets. Adm. Hosp.  
Address Ft. Howard, Maryland17. Burial Date thereof March 18/46  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director A. Lee OderAddress 4644 York Road., Balto., Md.19. 3-16 19 46  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 14, 1946, at 8:10 p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
December 14, 1946, to March 14, 1946and that I last saw him alive on March 14, 1946

Immediate cause of death

Generalized carcinomatosisDue to (Metastatic Carcinoma of the brain)Due to Bronchogenic carcinoma of right lung

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A.M. BalterA.M. BALTER, LT. COL., M.C. CLIN. DIR.  
Address Ft. Howard, Md. Date signed 3-15-46

Rec'd V.S.  
3-16-46

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

### 1. PLACE OF DEATH:

County Baltimore  
City or town Sparks (Rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 6 hrs.  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Sparks (Rural)  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Cedar Grove Road  
(If rural, give LOCATION)  
2(a) If veteran, name war

### 3. (a) FULL NAME

Ronald Le Roy Wertz

### 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Infant  
6. (b) Name of husband or wife  
6. (c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) 3-29-1946  
8. AGE: Years Months Days If less than one day  
6 hrs. 5 min.

9. Birthplace Sparks, Balt. Co. Md.  
(Town, county, and state)  
10. Usual occupation Infant  
11. Industry or business  
12. Name Charles Le Roy Wertz  
13. Birthplace Balto. Co. Md.  
14. Maiden name Mary Evelyn Nash  
15. Birthplace Balto. Co. Md.  
16. Informant Mary Evelyn Wertz  
Address Sparks, Balt. Co. Md.  
17. (Burial, cremation, or removal. Which?) Funeral Date thereof Mar. 30, 1946  
(month) (day) (year)  
Cemetery or crematory St. Joseph's Church  
Location Sparks, Md.  
18. Funeral director Landon M. Brooks  
Address Sparks, Md.  
19. Mar. 30 46 Wilmer C. Ensor  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1946 at 6 p.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3:29 to 3:29 and that I last saw him alive on 3:29  
Immediate cause of death Hemorrhage from  
nasal cannula  
DURATION 2 hrs.  
Due to  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)  
Major findings of operations  
Date of op.  
Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?  
23. SIGNATURE Maurine C. Parta  
Address Hampstead, Md. Date signed 3-29-46

MARGIN RESERVED FOR BINDING

9-45-15M

V5 A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
APR 2 1946  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-6

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

## 1. PLACE OF DEATH:

County BALTIMORE, MD.City or town RANDALLSTOWN, MD. (RURAL)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 WEEKS

Hospital, institution, or street address where death occurred:

BLACKSTONE ROAD

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNSYLVANIA County FRANKLINCity or town WYKESBORO  
(If outside city or town limits, write RURAL and give nearest town)Street No. 63 HIGHLAND AVE.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

CHARLES FRANKLIN WEST

## 3. (b) Social Security Number

173-03-3819

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED

6. (b) Name of husband or wife

CORA WEST

7. Birth date of

deceased (mo., day, yr.)

FEBRUARY 8, 1894

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

72115

hrs.

min.

9. Birthplace

UNKNOWN

(Town, county, and state)

10. Usual occupation

MOLDER

11. Industry or business

FOUNDRY

FATHER

12. Name

HENRY WEST

13. Birthplace

UNKNOWN

MOTHER

14. Maiden name

BARBARA DAVIS

15. Birthplace

UNKNOWN

16. Informant

FREDERICK T. RODGERS

Address

BLACKSTONE ROAD - RANDALLSTOWN - MD.

17.

BURIAL  
(Burial, cremation, or removal, Which?)

Date thereof

3/26/46  
(month) (day) (year)

Cemetery or crematory

CEMETERY MTZION

Location

FRANKLIN COUNTY PENNA.

18. Funeral director

WALTER Y. GROVE

Address

WYKESBORO, PENNA.

19.

3/23/46  
(Date rec'd by registrar)

1946

Mr. E. Martin

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 23, 1946 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 22, 1946 to Mar. 23, 1946and that I last saw him alive on March 23, 1946

Immediate cause of death

Carcinoma of stomach

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank E. Martin  
Randallstown

M. D. or other

Address

Date signed 3/23/46

DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
MAR 26 1946  
BUREAU V.S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

## CERTIFICATE OF DEATH

02465

Reg. Dist. No. 41

### 1. PLACE OF DEATH:

County Baltimore

City or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

46 Yorkway

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore

City or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 46 Yorkway  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

James W. Williams

### 3. (b) Social Security Number

#### 4. Sex

M & W.

#### 5. Color or race

#### 6.(a) Single, married, widowed, or divorced

M

#### 6.(b) Name of husband or wife

Dora M.

#### 7. Birth date of

deceased (mo., day, yr.)

Aug 31 - 1891

#### 6.(c) If alive, give age

years

#### 8. AGE:

Years

54

Months

6

Days

8

If less than one day

hrs.

min.

#### 9. Birthplace

Virginia  
(Town, county, and state)

#### 10. Usual occupation

R.R. Engineer

#### 11. Industry or business

Bethlehem Steel

#### FATHER

#### 12. Name

James Williams

#### 13. Birthplace

Va.

#### MOTHER

#### 14. Maiden name

Margaret Thompson

#### 15. Birthplace

Va.

#### 16. Informant

Dora M. Williams

#### Address

46 Yorkway - Dundalk.

#### 17.

(Burial, cremation, or removal, which?)

Date thereof

3/13/46  
(month) (day) (year)

#### Cemetery or crematory

U.S. National

#### Location

Baltimore

#### 18. Funeral director

W. H. Cook Inc.

#### Address

1217 St Paul St.

#### 19.

(Date rec'd by registrar)

3-12-46  
Registral

### MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 9 - 1946 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 - 1945 to Mar 8 - 1946

and that I last saw him alive on Mar 8 - 1946

Immediate cause of death Central embolism

#### DURATION

1 year

Due to

Hypertension

Due to

Atherosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

David H. Andrew M.D.

Address Chesapeake St. Dundalk Md. Date signed Mar 11, 1946

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 02466

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Balto. Co.

(c) Hospital or institution:

4142 Wilkins Ave

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Baltimore

(c) City or town Balto Md  
(If outside city or town limits, write RURAL and give town)(d) Street No. 4142 Wilkins Ave  
(If rural give location)(e) Citizen of foreign country? (Yes or No)  
If yes, name country

## 3 (a) FULL NAME

3 (b) If veteran, name war

(c) Social Security Account  
No. 214-01-5026

4. Sex

M

5. Color or race

W

6 (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6 (c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.)

2-30-1896

8. AGE: Years

50

Months

Days

17

If less than one day

hr.

min.

9. Birthplace

Balti

(Town, county, and state)

10. Usual Occupation

Retired Grocery

11. Industry or business

FATHER MOTHER

12. Name

John Wittmann

13. Birthplace

Germany

14. Maiden Name

Katharina

15. Birthplace

Germany

16 (a) Informant

Christopher Wittmann

(b) Address

4142 Wilkins Ave

17 (a)

(Burial, cremation, or removal)

Burial

(b) Date thereof

2-21-46

(month) (day) (year)

(c) Cemetery or crematory

Fountain Pk

Location

Frederick Rd

18 (a) Funeral director

Edward Foulson

(b) Address

2339 Wash Blvd

19 (a)

(b) (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 17 1946, at M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1946 - 17 1946, and that I last saw him alive on Jan 15 1946.

Immediate cause of death

Duration

Coronary

Due to occlusion

Due to coronary

Other Conditions

clerical

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

at

M

(c) Where did injury occur?

(City or town)

(County)

(State)

(d) Did injury occur about home, on farm, industrial place, in public place?

While at work?

(Specify type of place)

(e) Means of injury

23. Signature

Address

M.D.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

## 1. PLACE OF DEATH

County

Village or City

No.

Registration Dist. No.

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## 2. FULL NAME

(a) Residence: No.

(Usual place of abode)

St.

Ward.

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year)

7. AGE

Years

Months

Days

If LESS than

1 day, or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country)

13. NAME

14. BIRTHPLACE (city or town) (State or country)

15. MAIDEN NAME

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT (Address)

18. BURIAL, CREMATION, OR REMOVAL

Place

Date

19. UNDERTAKER (Address)

20. FILED

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

(Month)

(Day)

1934

22.

I HEREBY CERTIFY, That I attended deceased from

Mar 12, 1946, to

19

I last saw h. alive on 19; death is said

to have occurred on the date stated above, at 3:55 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Date of onset

Electrocution, by fire wire 6600 Volt.

Extensive 3rd degree

Other Contributory Causes of importance:

burns at head, neck &amp;

shoulder, arm &amp;

fracture both legs

Name of operation: fracture to be treated

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide

Where did injury occur? at Slob Mill, B. S. Co.

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury: Electrocution.

Nature of injury: 3rd degree burn.

24. Was disease or injury in any way related to occupation of deceased

If so, specify

(Signed)

(Address)

M. D.

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

**Example I**

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
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**Example II**

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9-34

## CERTIFICATE OF DEATH

02468

Reg. Dist. No. 38

1. PLACE OF DEATH: Baltimore  
 County.....  
 City or town.....Towson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 years  
 Hospital, institution, or street address where death occurred:  
102 E. Susquehanna Ave.  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....Maryland County.....Baltimore  
 City or town.....Towson  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 102 E. Susquehanna Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME Mary Elizabeth Zeigler

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband George W. Zeigler  
 7. Birth date of deceased (mo., day, yr.) Sept. 30, 1874 8. (c) If alive, give age 71 years  
 8. AGE: Years 71 Months 5 Days 28 If less than one day  
— hrs. — min.

9. Birthplace York County, Penna.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business At Home  
 12. Name Emma Marie Lehmann  
 13. Birthplace Penna.  
 14. Maiden name Anna Taylor  
 15. Birthplace Penna.

16. Informant George W. Zeigler  
 Address 102 E. Susquehanna Ave., Towson  
 17. Burial Date thereof Mar. 30, 1946  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory St. Paul's Reformed Church  
 Location York P.A.H., York Co., Penna.  
 18. Funeral director John Burns' Sons  
 Address Towson, Maryland  
 19. March 30, 46 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 28, 1946 at 6:30 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2, 46 to March 27, 46  
 and that I last saw her alive on March 27, 1946  
 Immediate cause of death Myocardial Decompensation DURATION 2 yrs.  
 Due to Arteriosclerosis  
 Due to Hypertension emb.  
 Other conditions.....  
 (Include pregnancy within 8 months of death)

Major findings of operations..... Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
 23. SIGNATURE John Zeigler M.D.  
March 29, 46 M. D. or other  
 Address..... Date signed.....



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BUREAU V.A.